



Department of Veterans Affairs  
Veterans Health Administration

# DISCOVERING FOR 6 2006

BALDRIGE  
CARES  
MILLENNIUM BILL



APRIL 2001

*Journey of Change: Corporate Report and Strategic Forecast*

## FOREWORD



The VA health care system has undergone a dramatic transformation. Between 1995 and today, we have made measurable and significant progress in improving the performance of our system. Our performance data demonstrate improved access, quality, safety, patient satisfaction, efficiency, and accountability.

Our nature is to plan to do what we can imagine based on what we know today. History has proven that we will underestimate the magnitude and types of change that will occur. Five years ago, few of us would have believed that Veterans Health Administration could have come this far.

Organizations must evolve to survive. This volume of the *Journey of Change - Discovering Six* for 2006 describes the progress we have made in 2000. In addition, it provides a framework for continued improvements into the future. By using the Baldrige criteria, recognized worldwide as the gold standard for quality, we can develop a new organizational skill of systematic self-examination as we continue our journey toward performance excellence. We look forward to exceeding today's vision and discovering what is truly possible.

A handwritten signature in blue ink that reads "Thomas L. Garthwaite".

***Thomas L. Garthwaite, M.D.***  
***Under Secretary for Health***





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# Introduction

The purpose of *Journey of Change - Discovering Six for 2006* is to

- Present the 2001 VHA Strategic Direction.
- Highlight 2000 accomplishments.
- Integrate network strategic plans with related national goals and strategies.

To ensure that VHA's transformation continues, the Under Secretary for Health has implemented a strategic vision grounded in six goals called the "6 for 2006." Supporting these goals is a platform of 21 strategies that capture VHA's highest operational priorities. The following are the "6 for 2006" goals:

- Put Quality First Until First in Quality.
- Provide Easy Access to Medical Knowledge, Care, and Expertise.
- Enhance, Preserve, and Restore Patient Function.
- Exceed Patients' Expectations.
- Maximize Resources to Benefit Veterans.
- Build Healthy Communities.

*Journey of Change - Discovering Six for 2006* summarizes 2000 accomplishments and sets the strategic direction for 2001–2006. As it goes forward, VHA will continue to focus on aspects of quality and performance: internal and external quality reviews; implementation of clinical guidelines and performance indices for chronic care, prevention and early detection with special attention to VHA special emphasis programs; patient and employee education and training; research; emergency management; and change management.

In addition, VHA's strategies focus on enhancing and expanding information systems both at the clinical and at the administrative level, integrating IT systems with the Veterans Benefits Administration to serve veterans as One VA, and increasing access to all veterans who choose VA for their health care.

VHA will apply for the President's Quality Award (PQA) in September. The award is given to government organizations exemplifying the Baldrige criteria for performance excellence, recognized worldwide as the gold standard for quality. By using Baldrige to examine VHA's strengths and opportunities to improve, VHA will continue the journey toward performance excellence. The "new VHA" sets the standard for national health care quality and provides cutting edge health care services, research, and education to optimize the health status of the Nation's veterans. It is VHA's employees who make it happen, and by applying for the PQA, VHA is seeking public recognition of their achievements.



# Chapter 1: Strategic Management

This chapter presents VHA Strategic Management issues in three sections:

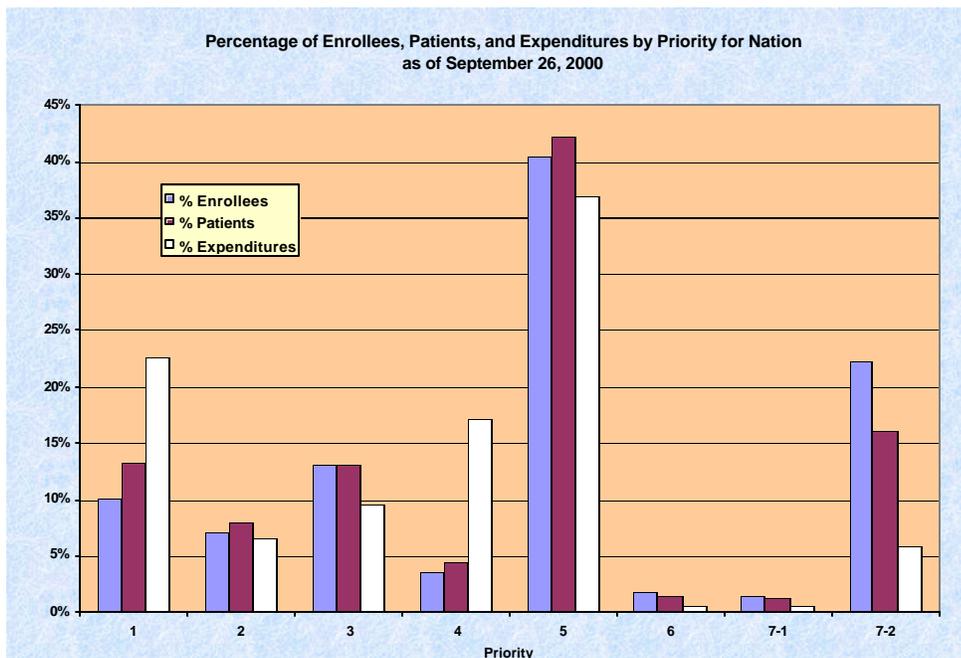
- ❑ Facts and Figures.
- ❑ Update on One VA.
- ❑ VHA's Six for 2006.

## FACTS AND FIGURES

VHA made many organizational and service delivery changes during the years preceding eligibility reform, and has further modified operations both to implement Public Law 104-262, the Veterans' Health Care Eligibility Reform Act of 1996, and to promote efficiency and effectiveness. Its efforts to improve access are occurring along with a fundamental transformation in the veterans national health care system — a focus on outpatient health care delivery, the delivery mode also emphasized by VHA since restructuring in 1995.

VHA's continued reorganization has also opened the way for rapidly expanding and integrating VA health care programs internally and with community resources. VHA is becoming a more population-focused, community-based and prevention-oriented system, ensuring that veterans receive timely, accessible, and appropriate care. VHA continues to closely monitor changes in enrollment, access, outcomes, utilization, expenditures, system capacity, quality, and veteran satisfaction.

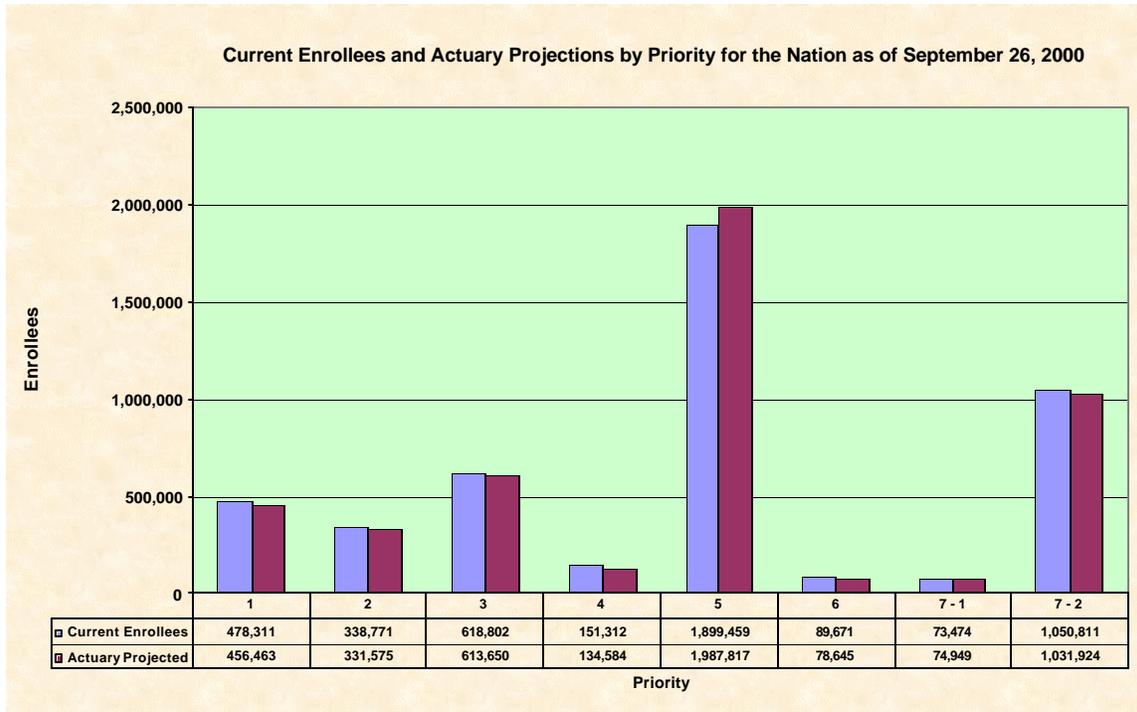
**Chart 1.1** Percentage of Enrollees, Patients, and Expenditures by Priority for Nation.



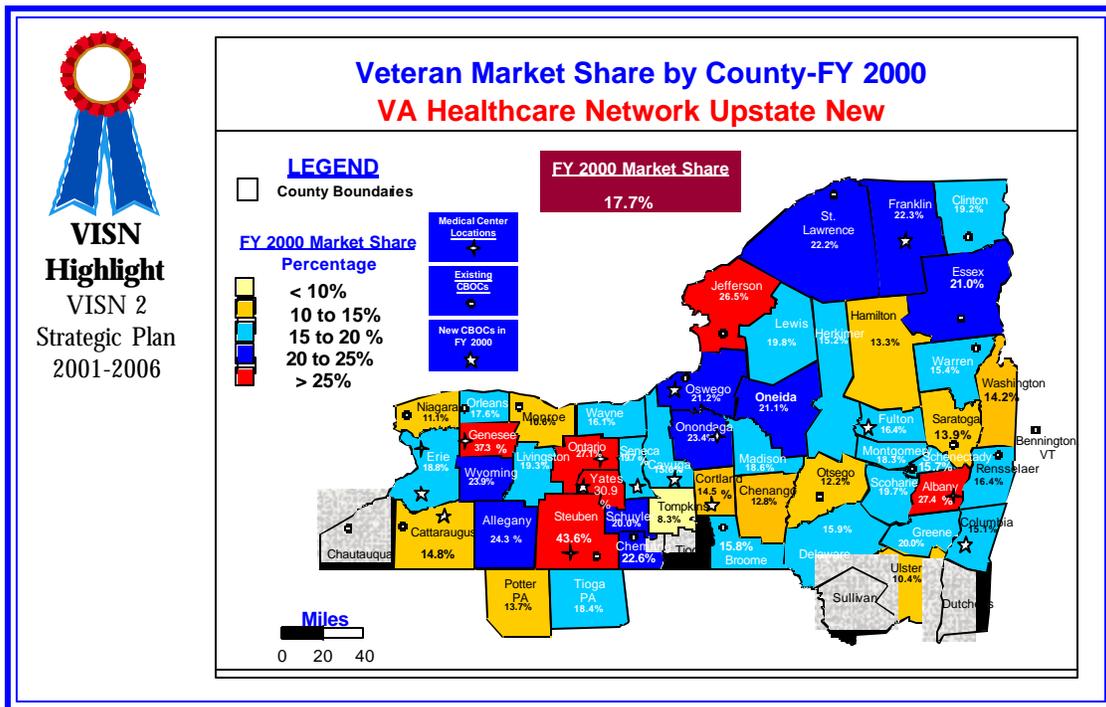
SOURCE: Office of Policy and Planning

# FACTS AND FIGURES (CONTINUED)

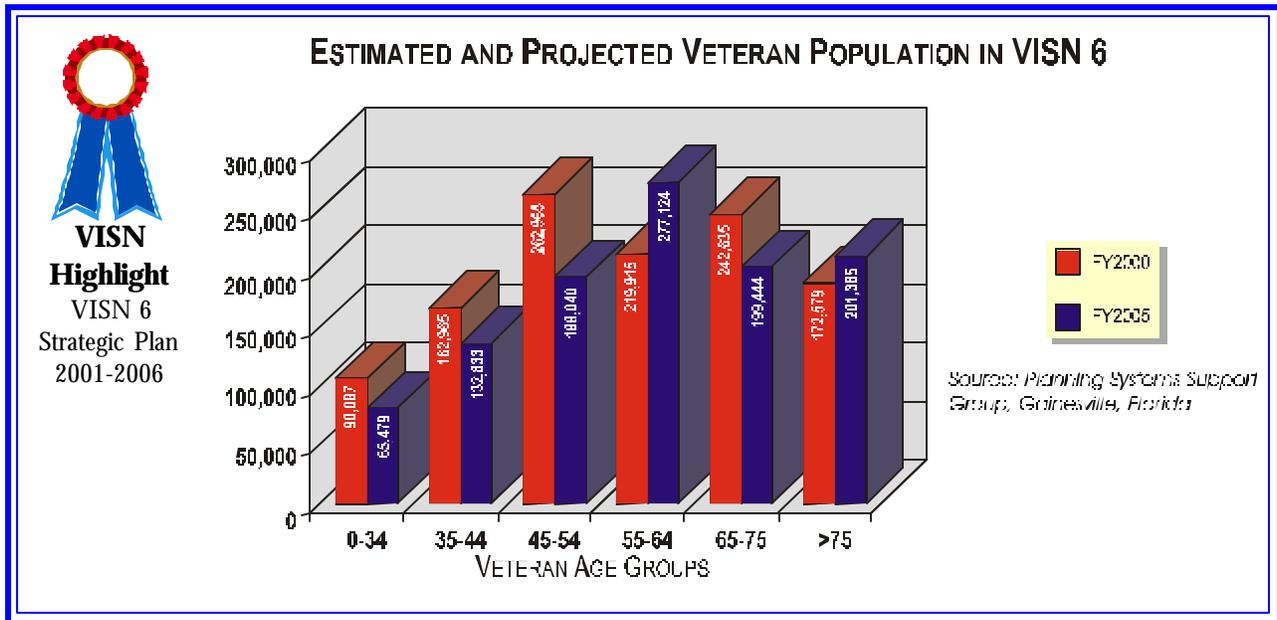
Chart 1.2 Current Enrollees and Actuary Projections by Priority for the Nation.



SOURCE: Office of Policy and Planning

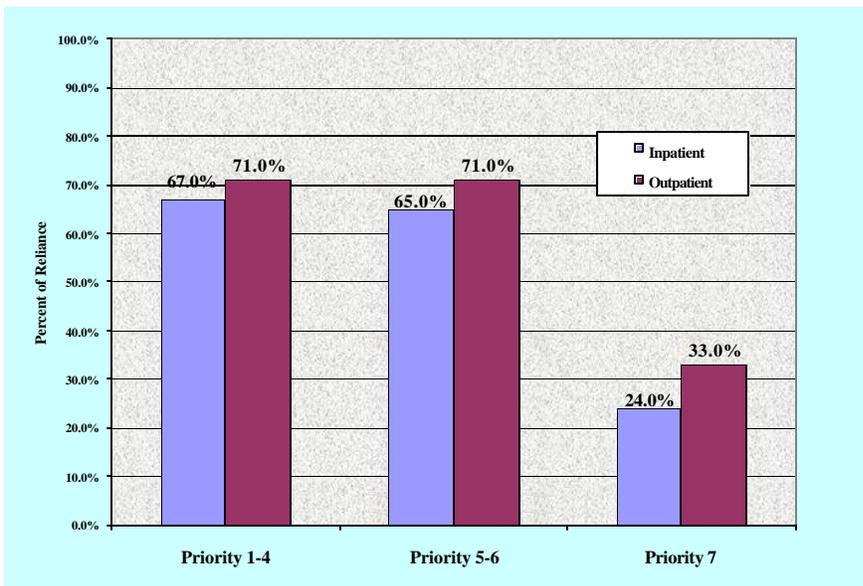


## FACTS AND FIGURES (CONTINUED)



The 1999 Survey of Veteran Enrollees' Health and Reliance Upon VA was conducted by VHA's Office of Policy and Planning using a stratified sample of approximately 27,000 non-institutionalized enrollees. 19,686 valid responses to the telephone survey were entered in the survey database—an overall response rate of almost 73 percent. The results were weighted to represent the population of 3.6 million veteran enrollees. The survey was conducted to provide VISN level data for use in actuarial enrollment, utilization and expenditure projections, and to examine assumptions or estimates of enrollee health status and catastrophic disability. Updates for Charts 1.1 and 1.2 are located in Appendix C. For additional information go to <http://vaww.va.gov/stratinit>.

**Chart 1.3** Veteran Reliance on VA Health Care by Priority.



SOURCE: Office of Policy and Planning

## UPDATE ON ONE VA

VA's mission is "To care for him who shall have borne the battle and for his widow and his orphan." These words were spoken by Abraham Lincoln during his second inaugural address and reflect the philosophy and principles that guide VA in everything it does. What is One VA? One VA is a way of capturing the concept that the different agencies within the Department of Veterans Affairs (VA) – Veterans Health Administration (VHA), Veterans Benefits Administration (VBA), and National Cemetery Administration (NCA) – are actually one entity. The VA exists to serve the veterans. Veterans do not distinguish between the various agencies and therefore, the agencies must provide seamless service regardless of the veterans' entry point.

The VA Strategic Plan integrates state-of-the-art planning techniques into a process that builds a strong and resilient strategic base for the future. VA has established five corporate goals, and all five apply directly to VHA programs.

Other areas of focus for VA strategic planning include the use of reengineering/restructuring and consolidation options, promotion of total quality improvement principles, and advances in technology to enhance current VA programs. For more information on One VA, see <http://vaww.va.gov/onevaactivities>.

Table 1.1 VA Strategic Goals.

### VA Strategic Goals

- ❑ **Restore the capability of disabled veterans to the greatest extent possible and improve their quality of life and that of their families.**
- ❑ **Ensure a smooth transition for veterans from active military service to civilian life.**
- ❑ **Honor and serve veterans in life and memorialize them in death for their sacrifices on behalf of the Nation.**
- ❑ **Contribute to the public health, socioeconomic well being and history of the Nation.**
- ❑ **Create an environment that fosters One VA world-class service to veterans and their families through the effective management of people, technology, processes, and financial resources.**

### 2000 Achievement Highlights

- ◆ Developed and distributed a One VA orientation tool kit to all VA facilities.
- ◆ Completed a series of Regional and VAHQ One VA conferences.



**VISN Highlight**  
VISN 5  
Strategic Plan  
2001-2006

### Processing Compensation & Pension (C&P) Examinations

In 2000, Veterans Benefits Administration made a concerted effort to process thousands of backlogged C&P examination requests. This in turn resulted in an overwhelming number of additional C&P exams being referred to the Washington DC VA Medical Center. As a result of this overwhelming number of C&P examinations, Washington saw their processing times climb to a 98 day average. The management staff effectively dealt with this challenge and by September 2000, the VISN ranked fourth in the country in terms of the lowest C&P processing times with an average of 26 days at the Network level.

## UPDATE ON ONE VA (CONTINUED)

### Plans for 2001 - 2006

- ◆ A One VA employee survey will be used to assess and improve employee satisfaction through a determination of where opportunities for improvement exist and through the development of integrated improvement plans around priority opportunities.
- ◆ Results from the National Survey of Veterans 2000 and the Survey of Women Veterans (Planned for 2001) will provide critical information to enhance VA planning and operational activities.
- ◆ By 2006, VA plans to make 150 interactive points of contact on its web site available to veterans.
- ◆ VA will implement a One VA IT Architecture to ensure IT functional capabilities that will contribute, in a coordinated way, to an environment of integrated services. VA will also implement an agency-wide information security management and planning program.

## VHA's SIX FOR 2006

The Department of Veterans Affairs has updated its strategic plan for the period of FY2002-2006. The Department's plan is grounded in the notion of One VA and is a unifying instrument for its component parts: VHA, VBA, NCA. VHA's strategic planning framework continues to evolve in concert with the shifts from inpatient hospital care to outpatient community-based care. The framework presented in last year's plan has been further refined and streamlined to support the Department's strategic goals and objectives while retaining the basic tenets of VHA's existing planning process.

To continue the progress started last year, the Under Secretary for Health unveiled a Six for 2006 strategic vision in 2000. This vision reflects VHA's highest priorities for health care, medical education, research, and backup to the Department of Defense (DoD). The vision has been translated into a planning framework comprised of six goals, 21 strategies, and roughly 40 strategic targets.

The integration of the Six for 2006 into the Annual Performance Plan ensures continued support for the Under Secretary for Health's strategic vision and, at the same time, compliance with the requirements of the Government Performance Results Act (GPRA) which calls for VA to report its annual performance to Congress.

The 21 strategies define how VHA is going to achieve its goals. Each addresses a different priority for the VA health care system. Whether by providing support to patients with disabilities or by adopting patient safety procedures in VA facilities, the strategies address specific initiatives VHA must pursue to reach its goals. A number of strategies have been carried over from last year's Performance Plan. Others are being established for the first time in 2002's Performance Plan.

Table 1.2 Goals, Strategies, and Strategic Targets.

<ul style="list-style-type: none"><li>✓ <b>Goals are overarching statements of purpose</b></li><li>✓ <b>Strategies give meaning and purpose to the goals by delineating how to achieve them</b></li><li>✓ <b>Strategic targets describe in definitive terms how VHA is going to achieve the strategies</b></li></ul>
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## VHA's SIX FOR 2006 (CONTINUED)

Table 1.3 Six for 2006 Goals and Strategies.

VHA Goals	VHA Strategies
I. Put Quality First Until We Are First in Quality	<ol style="list-style-type: none"> <li>1. Systematically measure and communicate the outcomes and quality of care.</li> <li>2. Continuously improve the quality and safety of health care for veterans.</li> <li>3. Emphasize Health Promotion and Disease Prevention to improve the health of the veteran population.</li> <li>4. Develop a performance-based system of incentives, awards, and recognition for achievement of VHA's 6 for 2006 mission and goals.</li> <li>5. Implement programs for employee training and personal development to ensure continual improvement of the knowledge and skills required to serve the veteran.</li> </ol>
II. Provide Easy Access to Medical Knowledge, Expertise, and Care	<ol style="list-style-type: none"> <li>6. Improve access, convenience, and timeliness of VA health care services.</li> <li>7. Optimize the use of health care information and technology for the benefit of the veteran.</li> <li>8. Increase provider and veterans' knowledge of the impact of military service on health.</li> </ol>
III. Enhance, Preserve, and Restore Patient Function	<ol style="list-style-type: none"> <li>9. Enhance outcomes for patients with special needs and special disabilities.</li> <li>10. Coordinate acute, chronic, and rehabilitative care to improve patient functioning.</li> </ol>
IV. Exceed Patients' Expectations	<ol style="list-style-type: none"> <li>11. Ensure that patients understand and participate in decisions about their health care.</li> <li>12. Create a health care environment characterized by courteous and coordinated patient-focused services.</li> <li>13. Continually assess and improve patients' perceptions of their VA health care.</li> <li>14. Promote cooperation and collaboration throughout VA in order to provide "One VA" seamless service to veterans.</li> </ol>
V. Maximize Resource Use To Benefit Veterans	<ol style="list-style-type: none"> <li>15. Assess and align the health care system to enhance cost-effective care for veterans.</li> <li>16. Increase revenue and efficiency through private sector partnerships, technology, and improved business practices.</li> </ol>
VI. Build Healthy Communities	<ol style="list-style-type: none"> <li>17. Be an industry leader in developing innovative approaches to the design and evaluation of health care delivery systems.</li> <li>18. Expand Federal, state, local, and private partnerships to foster improvements in the coordination and delivery of health care and other services.</li> <li>19. Develop new, state-of-the-art training programs to best educate the health care professionals of the future.</li> <li>20. Conduct medical research that leads to demonstrable improvements.</li> <li>21. Optimize VA's capability to provide medical assistance in response to disasters and national emergencies.</li> </ol>

## VHA's Six for 2006 (CONTINUED)

The strategic targets are the final component of the Annual Performance Plan. There are approximately 40 strategic targets and they serve as indicators of how and when the strategies will be accomplished. Strategic targets describe the entire range of clinical, administrative, and financial activities required to achieve the level of performance associated with each year of implementation. Each of the 21 strategies is supported by at least one strategic target. Certain criteria must be satisfied including: 1) wherever possible, targets are to be outcome as opposed to process oriented; 2) targets are to be quantitative in nature; and, 3) targets are to be data-driven and based upon sound scientific methodology. For more information on Six for 2006 go to <http://vaww.va.gov/6for2006>.

**Table 1.4** Six for 2006 Strategies and Targets for Quality.

VHA Goals	VHA Strategies	Strategic Targets
QUALITY	<ol style="list-style-type: none"> <li>1. Systematically measure and communicate the outcomes and quality of care.</li> <li>2. Continuously improve the quality and safety of health care for veterans.</li> <li>3. Emphasize Health Promotion and Disease Prevention to improve the health of the veteran population.</li> <li>4. Develop a performance-based system of incentives, awards, and recognition for achievement of VHA's 6 for 2006 mission and goals.</li> <li>5. Implement programs for employee training and personal development to ensure continual improvement of the knowledge and skills required to serve the veteran.</li> </ol>	<ol style="list-style-type: none"> <li>1.1. Improve performance on Chronic Disease Care Index II.</li> <li>1.2. Increase the percentage of patients treated for Hepatitis C when they are both Hepatitis C positive and treatment is medically appropriate and desired.</li> <li>1.3. Increase the percentage of all patients evaluated for the risk factors for Hepatitis C.</li> <li>1.4. Reduce the percentage of patients who use tobacco products.</li> <li>2.1. Maintain the percentage of Root Cause Analyses (RCA) that are completed in the correct format within 45 calendar days from the time an event is identified as requiring an RCA, or within the allocated extension time.</li> <li>3.1. Increase the scores on Prevention Index II.</li> <li>4.1. Employee satisfaction survey.</li> <li>5.1. Increase the percentage of full time employees who receive 40 hours of continuing education.</li> </ol>

# VHA's SIX FOR 2006 (CONTINUED)

**Table 1.5** Six for 2006 Strategies and Targets for Access and Function.

VHA Goals	VHA Strategies	Strategic Targets
A C C E S S	6. Improve access, convenience, and timeliness of VA health care services.	6.1. Increase the percent of enrolled veterans who will be able to obtain a non-urgent patient appointment with their primary care provider or other appropriate provider within 30 days.
	7. Optimize the use of health care information and technology for the benefit of the veteran.	6.2. Increase the percent of patients who will be able to obtain a non-urgent appointment with a specialist within 30 days of the date of referral.
		6.3. Increase the percentage of patients who report being seen within 20 minutes of their scheduled appointments at VA health care facilities.
	8. Increase provider and veterans' knowledge of the impact of military service on health.	6.4. Implement and maintain patient access to telephone care 7 days a week, 24 hours a day in all VISNs as follows: <ul style="list-style-type: none"> <li>• Number of VISNs providing basic telephone service</li> <li>• Number of VISNs fully compliant with VHA Directive 2000-035, except for accreditation and direct access by clinical staff to clinical medical records.</li> <li>• Number of VISNs providing direct access to clinical medical records and having applied for accreditation.</li> </ul>
		6.5. Increase the percent of enrolled veterans who have access to home and community-based care when clinically appropriate (FY2000 baseline = 14.111).
		7.1. Increase the percentage of applications received for VA health care via the Internet.
		8.1. Increase the percentage of eligible VHA staff who successfully complete the training program for the Special Recognition Program in Veterans Health (SRPVH).
	F U N C T I O N	9. Enhance outcomes for patients with special needs and special disabilities.
10. Coordinate acute, chronic, and rehabilitative care to improve patient functioning.		9.2. Maintain the percentage of veterans who acquired independent living at discharge from a Domiciliary Care for Homeless Veterans (DCHV) program or a community-based contract residential care program.
		9.3. Maintain the percentage of veterans who obtained employment upon discharge from a DCHV program or a community-based contract residential care program.
		9.4. Maintain the percentage of homeless patients with mental illness who received a follow-up mental health outpatient visit, admission to a CWT/TR, or admission to a PRRTF within 30 days of discharge.
		9.5. Maintain the rate of delayed prosthetics orders.
		9.6. Maintain the proportion of discharges from spinal cord injury (SCI) center bed sections to non-institutional settings.
		9.7. Increase the percentage of patients in specialized substance abuse treatment settings who have an initial Addiction Severity Index (ASI) and a six-month follow-up ASI.
		9.8. Increase the percentage of randomly selected discharges from SIPPS programs that are enrolled in the Outcomes Monitoring Program.
		10.1. Increase the average functional change of veterans undergoing rehabilitation for brain dysfunction in a medical rehabilitation unit.
		10.2. Increase the average Length of Stay Efficiency of veterans undergoing rehabilitation for a lower extremity amputation in a medical rehabilitation bed unit.

# VHA's SIX FOR 2006 (CONTINUED)

Table 1.6 Six for 2006 Strategies and Targets for Patient Satisfaction, Cost, and Healthy Communities.

VHA Goals	VHA Strategies	Strategic Targets
P A T I E N T  S A T I S F A C T I O N	<p>11. Ensure that patients understand and participate in decisions about their health care.</p> <p>12. Create a health care environment characterized by courteous and coordinated patient-focused services.</p> <p>13. Continually assess and improve patients' perceptions of their VA health care.</p> <p>14. Promote cooperation and collaboration throughout VA in order to provide "One VA" seamless service to veterans.</p>	<p>11.1. Decrease the percentage of patients who report problems in the following categories regarding their participation in health care decisions:</p> <ul style="list-style-type: none"> <li>• Patient involvement in decision-making.</li> <li>• Information on condition/treatment.</li> </ul> <p>12.1. Decrease the percentage of patients who report problems for the following Veterans Health Service Standards (VHSS):</p> <ul style="list-style-type: none"> <li>• Patient education.</li> <li>• Visit coordination.</li> <li>• Pharmacy.</li> </ul> <p>13.1. Increase the percentage of patients rating VA health care service as very good or excellent-Inpatient.</p> <p>13.2. Increase the percentage of patients rating VA health care service as very good or excellent-Outpatient.</p> <p>13.3. Increase the percentage of spinal cord injury respondents to the National Performance Data Feedback Center survey who rate their care as very good or excellent-Inpatient.</p> <p>13.4. Increase the percentage of spinal cord injury respondents to the National Performance Data Feedback Center survey who rate their care as very good or excellent-Outpatient.</p> <p>13.5. Maintain the proportion of veterans using Vet Centers who report being satisfied with services and say they would recommend the Vet Center to other veterans.</p> <p>14.1. Maintain the percent of electronic transmissions between VBA and VHA.</p>
C O S T	<p>15. Assess and align the health care system to enhance cost-effective care for veterans.</p> <p>16. Increase revenue and efficiency through private sector partnerships, technology, and improved business practices.</p>	<p>15.1. Increase the number of VISNs that perform CARES studies seeking to assess and realign the VA health care system in order to provide cost-effective care to veterans.</p> <p>16.1. Quality-Access-Satisfaction/Cost-Value Index.</p> <p>16.2. Balanced Scorecard: Quality- Access-Satisfaction/Cost.</p> <p>16.3. Increase the dollars derived from alternate revenue generated from health care cost recoveries.</p>
H E A L T H Y  C O M M U N I T I E S	<p>17. Be an industry leader in developing innovative approaches to the design and evaluation of health care delivery systems.</p> <p>18. Expand Federal, state, local, and private partnerships to foster improvements in the coordination and delivery of health care and other services.</p> <p>19. Develop new, state-of-the-art training programs to best educate the health care professionals of the future.</p> <p>20. Conduct medical research that leads to demonstrable improvements.</p> <p>21. Optimize VA's capability to provide medical assistance in response to disasters and national emergencies.</p>	<p>17.1. Increase by 5 percent over the previous fiscal year the number of HSR&amp;D-funded research projects related to health systems and methodology to evaluate outcomes.</p> <p>18.1. Increase the number and dollar volume of sharing agreements by 10 percent over the previous year (Baseline=FY2000).</p> <p>19.1. Increase medical residents' and other trainees' scores on a VHA survey assessing their clinical training experience.</p> <p>20.1. Increase Institutional Review Board (IRB) compliance with NCQA accreditation and maintain, as appropriate, AAALAC or NRC accreditation or certification.</p> <p>21.1. Increase the percentage of VA-managed Federal Coordinating Centers that complete at least one NDMS casualty reception exercise every three years.</p>

## VHA's SIX FOR 2006 (CONTINUED)

### 2000 Achievement Highlights

- ◆ The 22 Networks have adopted the 6 for 2006 as the framework for their planning activities as well as the structure for their strategic plans.
- ◆ Strategic targets have been developed for each of the 21 strategies and are incorporated in the 2002 Budget and Performance Plan.

### Plans for 2001 - 2006

- ◆ The strategic targets will be refined each year until they are exceptional indicators of achievement of the 21 strategies.
- ◆ The VHA Strategic Planning Council will continue to approve changes to the 6 for 2006.
- ◆ The Network Strategic Plans will provide VHA management critical input for maintaining and refining the 6 for 2006.
- ◆ In 2002, the 6 for 2006 framework will be integrated into the Network Performance Plan
- ◆ The 6 for 2006 will become the foundation for the strategic planning structure and processes required by the Baldrige initiative and will continue to serve as the basis for all VHA corporate reports.

## Chapter 2: Health Care Quality, Performance, and Patient Safety

VHA strives to improve quality of care through a comprehensive performance management system that aligns its vision and mission with quantifiable strategic goals; defines measures to track progress in meeting those goals; holds management accountable for results through performance agreements; and advances quality within the context of a full continuum of patient-centered care, while maintaining sound resource management. Improved quality is the result of actively managing performance. The integration of strategic objectives, evidence-based clinical guidelines, and data-driven management has resulted in significant improvement in the delivery of preventive health care and in the treatment of selected chronic diseases. Broad, statistically reliable, and ongoing performance measurement has resulted in a health care system that increasingly surpasses governmental and private sector goals. More importantly, the system has increased the number of additional lives saved.



In December 1999, the Institute of Medicine (IOM) released a report entitled “To Err is Human: Building a Safer Health System.” Using findings from the professional literature on hospital health care error research, the IOM report estimated that approximately 44,000 to 98,000 deaths occur in the U.S. consequent to adverse health care events. This landmark report also provided an important series of recommendations related to a range of issues including, but not limited to, event reporting, health care provider education and competency, and development of systems and methods to prevent errors. VA viewed the IOM report as validation of its dedication to continuously improving patient safety, and as a welcome opportunity to measure itself against the IOM recommendations.

This chapter covers:

- National Quality Indicators as related to VHA.
- National Center for Patient Safety.
- Accomplishment and Goals for Specific Patient Reported Outcomes.
- Reviews by Accrediting Organizations.
- Veteran Satisfaction.
- Awards for Quality.

For more information, go to <http://vaww.va.gov/quality> or <http://vaww.ncps.med.va.gov>.

## NATIONAL QUALITY INDICATORS AS RELATED TO VHA

An organization must know how it is currently performing in order to determine what it is doing well and where it can improve. By comparing: 1) VHA to others via nationally accepted guidelines and benchmarks, 2) VHA to VHA across the timeline of different fiscal years, and/or 3) VHA to VHA across the VISNs, VHA can identify successes as well as areas for improvement.



### 2000 Achievement Highlights

#### Chronic Disease Management

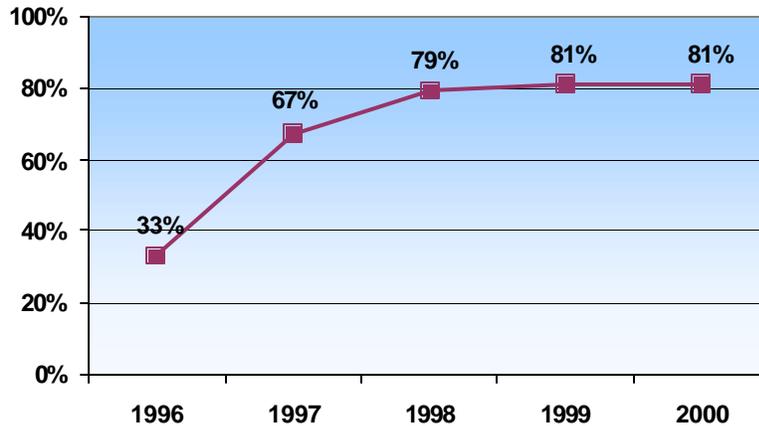
- ◆ Standard of practice calls for monitoring of Hemoglobin A1c, lipid testing, kidney disease screening, and annual retinal eye exams in diabetic patients.
  - ▲ 94% of diabetics in VHA had an annual Hemoglobin A1c. The 1999 National Committee of Quality Assurance (NCQA) national average performance was 75%.
  - ▲ VHA's 67% rate of retinal eye exams for diabetics exceeds the 1999 NCQA national average of 45%.
  - ▲ VHA's 54% rate of screening for kidney disease (nephropathy) for diabetics exceeds the 1999 NCQA national average of 36%.
  - ▲ VHA's 89% rate of lipid level testing (LDL-C) for diabetics in VHA exceeds the 1999 NCQA national average of 69%. Further, VHA's 76% rate of lipid level control (LDL-C <130 mg/dL) for diabetics exceeds the 1999 NCQA national average of 36.7%.
- ◆ National clinical guidelines recommend that beta-blockers and aspirin be administered following heart attack to reduce the risk of death or illness.
  - ▲ VHA's rate of administration of beta-blockers to clinically appropriate AMI patients has increased from a level in 1996 of 70% to an exceptional level in 2000 of 96%.
  - ▲ VHA's 98% rate of aspirin administration following an AMI continues to exceed private sector performance of 84% recorded in HCFA's Medicare Fee for Service program.

#### Prevention Index

- ◆ VHA's Prevention Index spotlights and summarizes a variety of evidence-based measures for high quality preventive health care.
- ◆ Breast and cervical cancer screening rates (90% and 93% respectively) exceed 1999 NCQA national average performance (73.4% and 71.8% respectively), as well as the Healthy People 2000 goals (60% and 85% respectively).
- ◆ Immunizations for pneumococcal disease (81%) and influenza (78%) in 2000 exceed the U.S. goal of 60%, established in the Healthy People 2000, by 21% and 18% respectively.
- ◆ 85% of elderly patients with chronic lung disease treated in VHA outpatient clinics received vaccinations for pneumonia and 79% received vaccinations for influenza.

## NATIONAL QUALITY INDICATORS AS RELATED TO VHA (CONTINUED)

Chart 2.1 Prevention Index: Nationwide Compliance Level of All Interventions.



SOURCE: Office of Quality and Performance

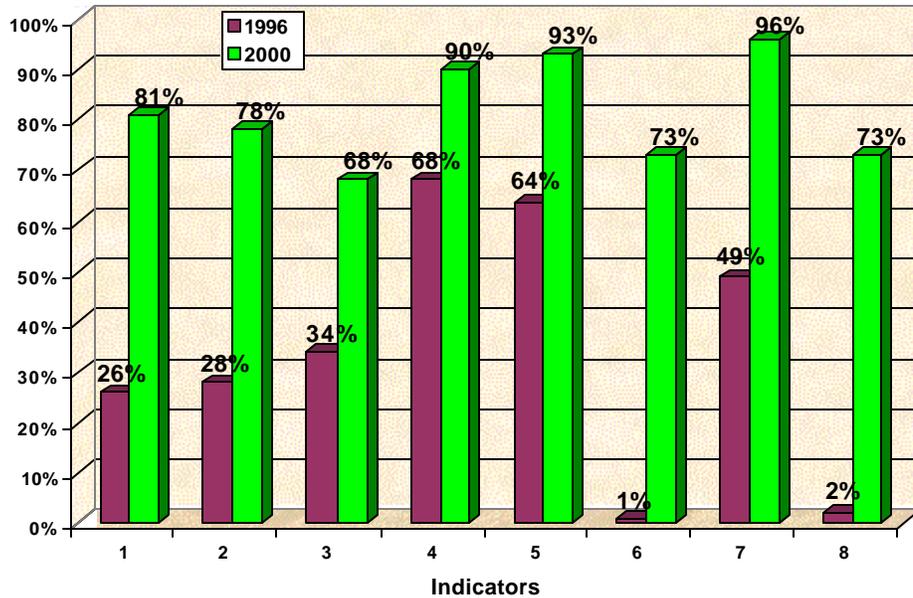
Table 2.1 Prevention Index Interventions.

CATEGORY	INDICATOR	INTERVENTION
IMMUNIZATIONS	1	Persons age 65 or older or at high risk of pneumococcal disease with documentation of ever receiving pneumococcal vaccine.
	2	Persons age 65 or older or at high risk of influenza with documentation of receiving influenza vaccine in past year.
CANCER SCREENING	3	Persons age 50 or older with documentation of serial fecal occult blood screening in the past year or sigmoidoscopy in the past five years or colonoscopy in past 10 years.
	4	Females age 50-69 with documentation of mammography in past two years.
	5	Females age 65 and younger who have not had a hysterectomy with documentation of receiving a Pap smear in the past three years.
	6	Males age 50 and older with documentation in the chart, within the past year, of a discussion of options and benefits of prostate cancer screening.
TOBACCO CONSUMPTION	7	Persons whose charts document annual screen for use of tobacco products.
ALCOHOL CONSUMPTION	8	Persons whose charts document annual screening for problem alcohol consumption using a standardized instrument.

SOURCE: Office of Quality and Performance

## NATIONAL QUALITY INDICATORS AS RELATED TO VHA (CONTINUED)

**Chart 2.2** Prevention Indicators: Nationwide Compliance Level of Each Intervention.



SOURCE: 2000 Network Performance Report

NOTE: BASELINE EQUALS 1996, INDICATORS ARE DEFINED IN TABLE 2.1

### Plans for 2001 - 2006

- ◆ Continue to focus Network Performance Plan to assure consistency with VHA Strategic Plan.
- ◆ Analyze “gaps” in organizational performance to continue to identify opportunities for improvement.
- ◆ Expand use of benchmarks and comparative data.
- ◆ Develop methodology for customizing Network Performance Plans to address potential areas needing improvement.
- ◆ Development of an interactive web site that will provide current results, comparative information, and identify best practices for dissemination.

## ACCOMPLISHMENTS AND GOALS FOR SPECIFIC PATIENT REPORTED OUTCOMES

The list of improvements in outcome is long, but the following outline a few of the most compelling examples and the implications for veterans:

- ❑ Patients over 65 with lung disease who receive both pneumonia and influenza vaccines are 72% less likely to be hospitalized and 82% less likely to die in a similar time period than unvaccinated peers. VHA greatly improved its performance in pneumonia and influenza vaccination. It is estimated that over 3,900 deaths were prevented in patients with lung disease.
- ❑ Diabetes is the leading cause of non-traumatic amputation. Evidence based quality-of-care indicators about foot care are associated with better outcomes for patients with diabetes. While full causality cannot be inferred, age-standardized amputation rates appear to be decreasing for VHA.
- ❑ It has been well-known since the late 1980's that medications referred to as "beta blockers" reduce death, re-hospitalization, and expense after heart attacks in eligible patients. Despite this, provision of beta blockers to eligible patients remains about 51% in a recent study of 58,000 non-governmental patients. VHA's rate of 97% is a national benchmark. VHA's rate of this and other quality-of-care markers in heart disease are better than the performance of major academic medical centers as reported in a recent article in the Journal of the American Medical Association.

## VETERAN SATISFACTION

VHA relies heavily on periodic feedback from veterans as to the level of their satisfaction with service obtained through surveys, focus groups, complaint handling, and patient advocates. In 1993, VHA established the National Performance Data Feedback Center to focus on veteran satisfaction surveys. VHA developed a partnership with the Picker-Commonwealth Foundation of Boston, MA. Picker Institute has been a leader in assessing non-VA patient experiences with health care since 1987. The Picker Institute has surveyed patients receiving health care in a variety of settings, including health plans, hospitals, clinics, physician practices, and business/purchasing coalitions. These surveys allow for comparisons between private sector and VHA.

Formal satisfaction surveying allows VHA to better understand and meet patient needs. The surveys target the dimensions of care that patients are most concerned about as validated by VA patients during a series of focus groups held throughout the country. The questions that are asked of the veteran are then categorized into the following main areas:

- ❑ Access to care.
- ❑ Preferences.
- ❑ Coordination of care (overall).
- ❑ Coordination of care (visit).
- ❑ Information and education.
- ❑ Courtesy.
- ❑ Emotional support.
- ❑ Transition and continuity of care.
- ❑ Pharmacy.

Surveys are sent to patients who have received care in a variety of settings, e.g., inpatient, outpatient, mental health, home-based hospital care, and certain special emphasis programs such as SCI and Gulf War. VHA continues to use non-VA benchmarks drawn from the database compiled by the Picker Institute that represents similar academic and non-affiliated health care institutions across the country.

VHA's veteran satisfaction performance is externally benchmarked to other large organizations. This benchmarking is performed by the American Society for Quality (ASQ), CFI Group, and the University of Michigan Business School using the American Customer Satisfaction Index (ACSI).

## VETERAN SATISFACTION (CONTINUED)

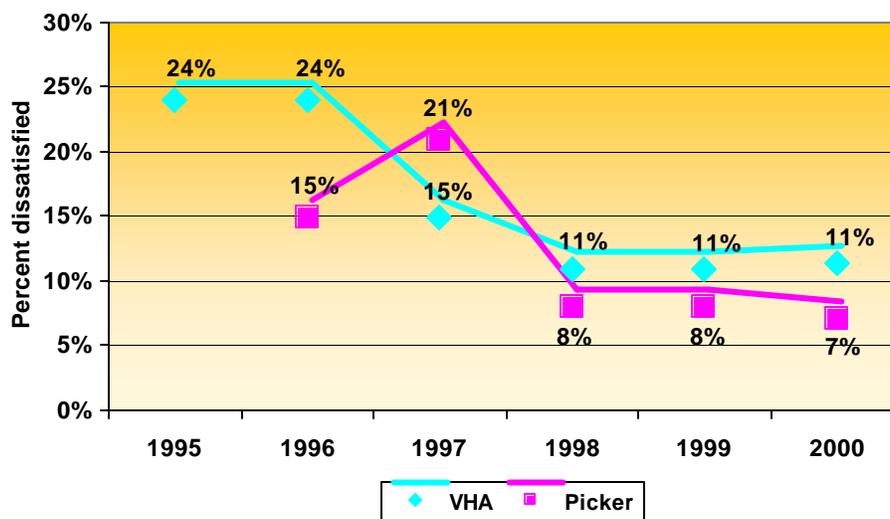
ACSI was developed by the National Quality Research Center at the University of Michigan Business School. The Index was developed to provide useful information on quality to complement present measures of the U.S. economy. Prior to the development of ACSI, a uniform national measure of quality had been missing from the list of economic indicators.

- Index reflects customer evaluations of the quality of goods and services.
- ACSI is based on findings from telephone interviews from a national sample of almost 50,000 customers. Respondents are selected on the basis of having recently bought or used a company's product or service.
- ACSI uses a tested, multi-equation, econometric model to produce four levels of indices or scores: a national customer satisfaction score, seven economic sector scores, 34 specific industry scores, and the scores from 200 companies and agencies within those industries.
- The company and agency scores are the building blocks for the national, sector, and industry scores. Each of these measures is based on a scale of zero to 100, with zero being the lowest and 100 being the highest possible score.

### 2000 Achievement Highlights

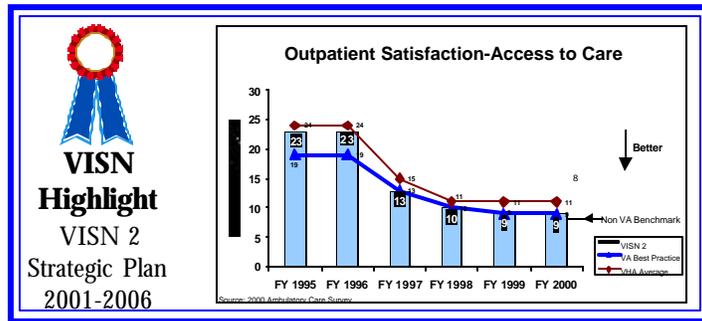
- ◆ VHA scored 78 out of 100 points on the ACSI for 2000. VHA's scores compared favorably with the score of 69 for U.S. hospitals overall and the score of 20 for service industries. The Customer Service Scores of 87 and the Loyalty score of 88 (reflecting the likelihood of using the services again given a choice) were among the highest scores achieved by all organizations.
- ◆ VHA compares the results of their own survey to a non-VA benchmark from the database of the Picker Institute. The goal of veteran satisfaction is to provide service that will meet or exceed their expectations. Problem rates for veterans overall have decreased since the inception of the surveys.
- ◆ VHA has made steady improvement in two areas – access and courtesy.

**Chart 2.3** Comparison of Veterans Health Care Satisfaction Survey Results for Access with Picker Scores (non-VA Benchmark). Lower Score is Better.

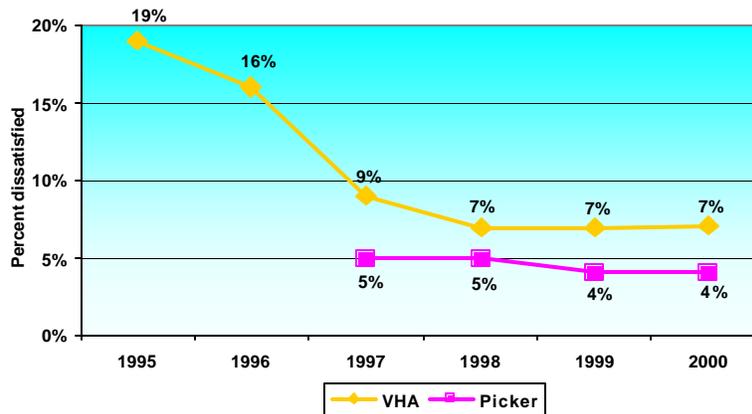


SOURCE: Office of Quality and Performance

# VETERAN SATISFACTION (CONTINUED)

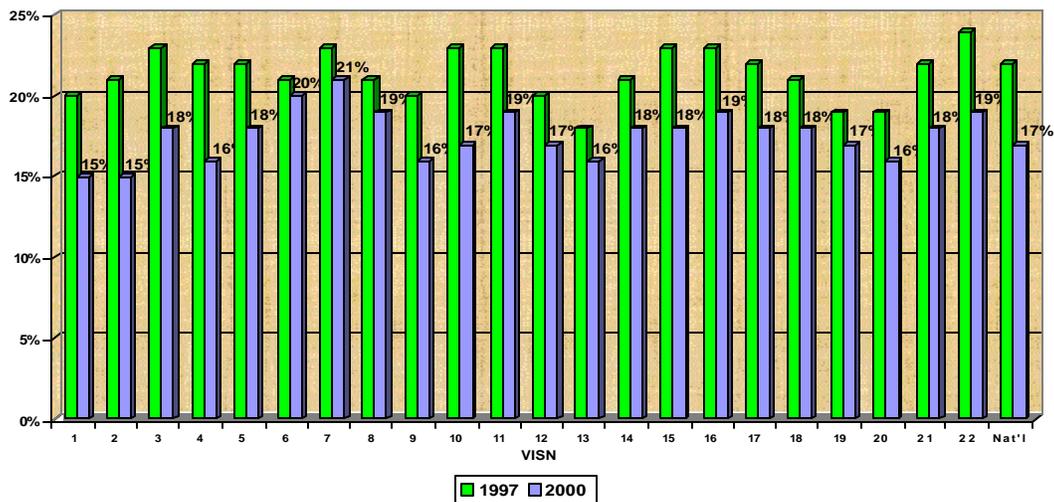


**Chart 2.4** Comparison of Veterans Health Care Satisfaction Survey Results for Courtesy with Picker Scores (non-VA Benchmark). Lower Score is Better.



SOURCE: Office of Quality and Performance

**Chart 2.5** Average Percentage of Problems Reported Per Patient. Lower Score is Better.



SOURCE: 2000 Network Performance Report

## VETERAN SATISFACTION (CONTINUED)

### Plans for 2001 - 2006

- ◆ Increase frequency of the Ambulatory Care survey to semi-annual.
- ◆ Focus performance improvement efforts on areas that provide the greatest opportunity for improvement.
- ◆ Development of a survey “tool kit” that allows for immediate, local results that can be compared to the national results. Allows for “real-time” evaluation of the effectiveness of actions taken to improve patient satisfaction.

## NATIONAL CENTER FOR PATIENT SAFETY

VHA’s National Center for Patient Safety (NCPS) was created in 1998 to take the lead in integrating patient safety efforts and innovations, and to develop and nurture a culture of safety throughout VHA. NCPS’s primary goal is nationwide reduction and prevention of adverse events and close calls. Intense training for all VA facilities and networks in rigorous, uniform root cause and contributing factor analysis of adverse event and close call situations has been accomplished. This is leading to actions that are effective in eliminating or correcting such situations. NCPS training uses state-of-the-art human factors and safety system approaches in patient care settings. The processes and outcomes of root cause and contributing factor analysis and resulting actions are being electronically documented, monitored, and analyzed by a patient safety information reporting system administered by NCPS. NCPS also directs four applied research centers, known as Patient Safety Centers of Inquiry (PSCI), that are charged to develop practical solutions to eliminate, reduce, or prevent selected classes of patient safety adverse events.

### 2000 Achievement Highlights

- ◆ NCPS staff trained over 700 VA nurses, physicians, pharmacists and other health care professionals in techniques that are pivotal to insuring patient safety. These NCPS developed techniques were so well regarded that VA was also asked by numerous outside organizations — such as the Department of Defense, Food and Drug Administration (FDA), Kaiser Permanente and the University of Michigan — to provide them training in this area.
- ◆ Distributed a revised Patient Safety Handbook and provided training for health care workers.
- ◆ NCPS was chosen as a finalist in the prestigious 2000 Innovations in American Government Awards Program for initiating a systems approach to ensuring the safety of VA patients.
- ◆ Roll-out of comprehensive Adverse Event and Close Call Analysis Program.
- ◆ Chosen by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to be a reviewer of draft revisions to Joint Commission Standards in Support of Patient Safety and Medical Health Care Error Reduction.
- ◆ Signed an agreement with NASA to implement a national Patient Safety Reporting System (PSRS).
- ◆ Produced a breakthrough series on reducing adverse drug events in VHA, and developed the capacity to deliver facilitated quality improvement projects designed to translate research and best practices in patient safety into front line practice.
- ◆ Continued to be a world center for teamwork and anesthesia/operating room simulation training, with training provided for VHA personnel, and public and private health care providers (including personnel from Australia and the United Kingdom).

## NATIONAL CENTER FOR PATIENT SAFETY (CONTINUED)

### Plans for 2001 - 2006

- ◆ Continue to monitor patient safety attitudes through use of patient safety culture surveys.
- ◆ Have the VA/NASA Patient Safety Reporting System (PSRS) running throughout the entire VHA. PSRS will augment the VA's internal error reporting system that is implemented by the NCPS.
- ◆ Development and implementation of an advanced training course for those who have received the initial NCPS training and implemented the techniques and methodologies learned.
- ◆ Continue efforts to improve the understanding of diffusion of innovation in patient safety.
- ◆ Continue efforts for enhancing mobility, fall risk assessment and fall reduction, and design an optimally safe patient room for any health care setting.
- ◆ Produce a periodic patient safety publication to further efforts within VA as well as have utility to the health care field at large.
- ◆ Continue research on the effects of fatigue on clinicians.
- ◆ Continue ongoing patient safety training for VHA health care professionals.
- ◆ Establish a segment on patient safety in the orientation provided to all new VA employees.
- ◆ Continue the exploration of communication glitches and issues related to human-machine interfaces.
- ◆ Continue to expand the utility of medical care simulation to improve the care provided to VA patients.

## REVIEWS BY ACCREDITING ORGANIZATIONS

Another major indicator of quality care is approval by a formal body with accreditation or licensing jurisdiction, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF).

VHA facilities have been reviewed and accredited by JCAHO for many years, and VHA now has CARF accredited rehabilitation programs. It has been VHA's historical mission to provide state-of-the-art services for emotionally and physically disabled veterans in need of rehabilitation. Standards published by CARF are consumer-focused, field-driven, and state-of-the-art national standards for rehabilitation.

Accreditation by JCAHO is recognized nationally as a symbol of quality and is considered by VA as one of its major external quality reviews. JCAHO accreditation confers recognition that health care organizations meet certain standards of quality and safety. In addition, accreditation confers deemed compliance with the health care quality standards of payors, both public (e.g., Medicare) and commercial. Of the 45 VHA facilities surveyed by JCAHO in 1999, the average VA hospital score was 90 as compared to the private sector hospital score of 91.

In addition, the seven VHA Consolidated Mail Out Pharmacies were surveyed by JCAHO in 1999. All were accredited and six of these pharmacies received Accreditation with Commendation. (The CMOP program originated in VA in the early 1990s and has grown considerably since then. In 2000, approximately 50 million outpatient prescriptions were processed through these highly automated facilities.)



## AWARDS FOR QUALITY

The Baldrige Award is the highest quality award in the United States. Awards internal to VA that utilize the Baldrige Criteria are the Robert W. Carey Award and the Quality Achievement Recognition Grant. The Presidential Award is the government adoption of the Baldrige Award process. The criteria consist of seven categories: 1) Leadership, 2) Strategic Planning, 3) Focus on Patients, other Customers, and Markets, 4) Information and Analysis, 5) Staff Focus, 6) Process Management, and 7) Organizational Performance Results. The criteria provide a systems perspective for managing an organization and achieving performance excellence.

In 2000, Tampa Veterans Affairs Hospital won the Presidential Quality Achievement Award. This is the highest honor conferred on a VHA facility since the Award's inception in 1990. VHA had two winners for the Carey Award, VA's internal Baldrige Award. Erie Veterans Affairs Hospital won the highest award; and Amarillo Veterans Affairs Hospital won the Health Care Category Carey Award. VHA's Quality Achievement Recognition Grant Program had seven applicants for this quality Award. VISN 20 won the \$300,000 award and VISNs 2 and 8 won an achievement award. All awards identify exemplary practices that applicants are encouraged to share to improve the care to veterans overall.

Rochester Institute of Technology (RIT) and USA Today award Quality Cups to businesses and industries that utilize teams who make dramatic improvements in the quality of goods and services that they provide. VHA's Bar Code Medication Administration Team was recognized as a finalist for this Award. VHA's Strategic Healthcare Group for Occupational and Environmental Health team was recognized as a semifinalist.



The Innovations in American Government Program identifies and promotes creative problem solving in the public sector through an annual awards program. Building on a rigorous, four-stage evaluation process, the Program confers broad public recognition on innovative government programs nationwide. Harvard University's Kennedy School of Government administers the Innovations Program. VHA's Performance Measurement Program was a semi-finalist for this award in 2000.

## Chapter 3: Special Activities

There are approximately 4.7 million veterans enrolled in the Veterans Health Administration (VHA). VHA's mission is to ensure that the health care needs of these veterans are accommodated by providing them with primary care, specialized care, and related medical and social support services. Approximately 75 percent of the enrolled veterans are eligible for care due to disorders that are service connected or through economic circumstances.

This chapter highlights key 2000 accomplishments and 2001 goals for:

- ❑ Baldrige Health Care Criteria for Performance Excellence.
- ❑ Capital Asset Realignment for Enhanced Services (CARES) Program.
- ❑ Special Emphasis Programs.
- ❑ Hepatitis C.
- ❑ National Center for Ethics.

### BALDRIGE HEALTH CARE CRITERIA FOR PERFORMANCE EXCELLENCE

A fundamental feature of VHA's remarkable transformation over the past five years has been the use of performance measures to guide the system toward performance improvement. VHA has now decided it is in a position to measure itself as an organization against the Baldrige Health Care Criteria for Performance Excellence by applying for the Malcolm Baldrige National Quality Award. This process will enable VHA to assess its strengths and weaknesses and focus on opportunities for further organizational improvement.



The Baldrige National Quality Program, administered by the Department of Commerce, is the nationally recognized gold standard for quality. Seeking this award as a national system will provide focus, structure, and context for a wide variety of quality improvement efforts throughout the VA system. It provides a comprehensive blueprint for achieving VHA's mission of improving the health of veterans and a platform on which to display achievements as well as ongoing improvements. Pursuit of the Baldrige Award is mobilizing employees at every VHA level and involvement of every employee.

#### 2000 Achievement Highlights

- ◆ VHA's Chief Officers and Network Directors personally began the self-assessment process, using Baldrige tools.
- ◆ Obtained services of the Federal Consulting Group to help structure the first two years of VHA's Baldrige initiative.
- ◆ Developed a comprehensive plan of communications to assure that all VHA employees get the right messages about the Baldrige initiative at the right time.

## BALDRIGE HEALTH CARE CRITERIA FOR PERFORMANCE EXCELLENCE (CONTINUED)

### Plans for 2001 - 2006

- ◆ All VHA employees will be engaged in the Baldrige initiative.
- ◆ VHA will conduct a full criteria-based self-assessment of the management system, from levels of senior leadership to first line contacts for patients and other customers.
- ◆ VHA will report self-assessment results in applications for the President's Quality Award (2002) and the Malcolm Baldrige National Quality Award for Health Care (2003).

## CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES (CARES) PROGRAM

A March 1999 General Accounting Office (GAO) report concluded that VHA could significantly reduce the funds used to operate and maintain its capital infrastructure by developing and implementing market-based plans for restructuring assets. In response to the GAO report, VHA initiated the development of the CARES project. The CARES program will assess veteran health care needs in VHA networks, identify service delivery options to meet those needs in the future, and guide the realignment and allocation of capital assets to support the delivery of health care services. CARES will improve quality as measured by access and veteran satisfaction, and improve the delivery of health care in the most accessible and cost-effective manner, while maximizing positive influences and minimizing any adverse impacts on staffing and communities and on other VA missions.



VHA's current health care delivery model emphasizes a continuum of care provided within a regional or network-based integrated delivery system. The existing capital infrastructure was designed primarily for inpatient care and, as a result, VHA's capital assets do not align with current health care needs for optimal efficiency in many cases. The cost to maintain and operate VA health care facilities that cannot provide efficient and accessible services substantially diminishes resources that could otherwise be used to provide better care in more appropriate settings. VHA's National Strategic Planning Guidance sets forth requirements for network strategic plans to clearly identify health care needs of the veteran population served by that Network, and articulates a framework to develop strategic plans to address those needs. Health care needs identified in the strategic plans will provide the context and the framework for capital asset management decisions. The CARES program, through network-based planning, will facilitate identification of projected veterans' health care needs and promote subsequent corresponding strategic realignment of capital assets linked to those needs. CARES will improve access and enhance VHA's delivery of health care by maintaining an environment that maximizes the quality of health care.

### 2000 Achievement Highlights

- ◆ Developed VHA Directive 2000-040, Capital Asset Realignment for Enhanced Services (CARES) Program.
- ◆ Established a multidisciplinary National CARES Project Team (NCPT).
- ◆ Established National CARES Steering Committee (NCSC).
- ◆ Awarded CARES contract to Booz-Allen-Hamilton (November 2000).
- ◆ Sponsored a CARES kick-off meeting for Phase I and II Network Support Task Forces (November 2000).

## CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES (CARES) PROGRAM (CONTINUED)

### Plans for 2001 - 2006

- ◆ Appointment of a CARES Director, reporting to the Deputy Under Secretary for Health.
- ◆ Implement Phase I in January of 2001. It will be the pilot test for CARES and will concentrate on the Network 12 study.
- ◆ Phase II will take approximately one year and will concentrate on Networks 1, 3, 4, 11, 21, 22, and one other network to be named.
- ◆ Phase III will concentrate on the final 14 networks.

## SPECIAL EMPHASIS PROGRAMS

There are a number of clinical and administrative programs in VA that have been designated as Special Emphasis programs (SEPs). Typically, SEPs are clinical services that address illnesses specific to the service-connected veteran population, constitute areas of special VA expertise, or are unique programs that address the psycho-social needs of certain identified veterans.

Public Law (P.L.) 104-262 mandated that the VA ensure capacity for veterans with spinal cord injuries and diseases, blinded veterans, veterans with amputations, and veterans with severely, chronic, disabling mental illnesses. The law also required the publication of data in an annual report (the "Capacity Report") to Congress demonstrating VA's compliance with the provisions of this mandate. In November 2000, a Coordinator for Special Disabilities (CSD) was appointed by the Under Secretary for Health. This section presents 2001 goals and 2000 highlights for several of the SEPs with a focus on improvements in quality, access, and patient functional status.

### Homelessness

It has been estimated that there are 250,000 homeless veterans in the nation each night with over half suffering from serious psychiatric or addictive disorders. Since 1987, VHA has operated the single largest network of programs, providing medical assistance to homeless people with mental illness. This program consists of multiple components including community-based outreach, case management, residential treatment, supportive housing, compensated work therapy, and has treated well over 200,000 veterans since its inception. Major components were established by law and include the Health Care for Homeless Veterans Program (HCHV); the Domiciliary Care for Homeless Veterans Program (DCHV); the Homeless Providers Grant and Per Diem Program (GPD); and the Community Homeless Assessment, Local Education, and Networking Groups (CHALENG) for veterans. For more information on homelessness, go to <http://vaww.va.gov/health/homeless>.

### 2000 Achievement Highlights

- ◆ HCHV Program staff nationally conducted outreach assessments on 28,397 unique veterans and provided residential treatment to approximately 4,000.
- ◆ DCHV Program provided treatment to 5,012 veterans and 2,017 beds were in operation under the GPD Program.
- ◆ Over 100 HCHV case managers provided long-term case management to homeless veterans with mental illness through VA Supported Housing Programs.
- ◆ VA staff participated in 184 Stand Downs for homeless veterans.

## SPECIAL EMPHASIS PROGRAMS (CONTINUED)

### Homelessness (continued)

#### 2000 Achievement Highlights

- ◆ VA identified \$50 million to expand homeless services throughout the nation which included:
  - ▲ 53 demonstration programs to address the special needs of homeless female veterans, therapeutic employment, community adjustment, and dental services.
  - ▲ 66 new HCHV sites, along with new staff at selected existing programs.

#### Plans for 2001 - 2006

- ◆ Complete implementation of new initiatives.
- ◆ Training programs for new staff and staff implementing new programs.
- ◆ Finalize the Loan Guarantee for Multi-family Transitional Housing for Homeless Veterans Program.



### Seriously Mentally Ill (SMI)

The SMI program is the largest mental health program in the country, providing state-of-the-art diagnosis and treatment to improve the mental and physical functioning of veterans in need of mental health treatment across a broad continuum of inpatient, partial hospitalization, outpatient, and community settings. For more information, go to <http://vawww.mentalhealth.med.va.gov>.

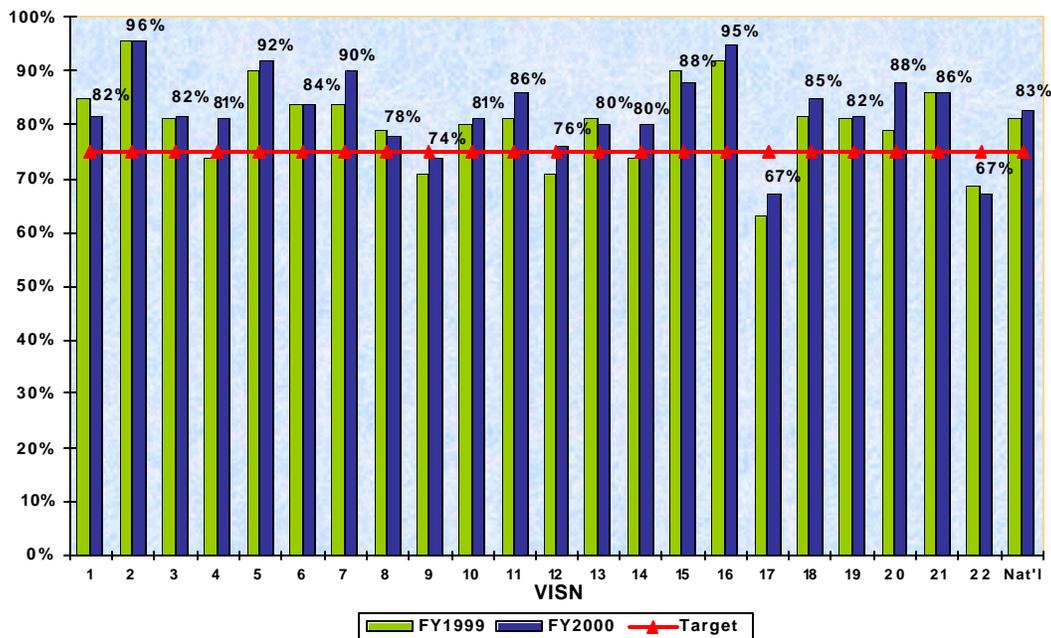
#### 2000 Achievement Highlights

- ◆ Increase in numbers of unique SMI patients treated in VA settings with further shift to outpatient modalities.
- ◆ Increase to 83% of psychiatric inpatients being seen in outpatient settings within 30 days—8% over the target (see Chart 3.1).
- ◆ Technical details finally worked out in transmission of GAF data to Austin with all facilities now participating.
- ◆ Increase in number of CBOCs offering mental health services to at least 2% of unique veterans, ranging from 55% in small (< 100 patients) clinics, to 71% in large (> 1000 patients) clinics.

## SPECIAL EMPHASIS PROGRAMS (CONTINUED)

### Seriously Mentally Ill (SMI) (continued)

Chart 3.1 Percentage of Patients with Follow-up after Hospitalization for Mental Illness.



SOURCE: 2000 Network Performance Report

### Plans for 2001 - 2006

- ◆ Further expansion of mental health services into CBOCs (Community-Based Outpatient Clinic).
- ◆ Assessment of usefulness of the Global Assessment of Functioning (GAF) scale for defining SMI patients, and for measuring one aspect of outcomes of mental health treatment.
- ◆ Expansion of Mental Health Intensive Case Management programs where appropriate.
- ◆ Attention to remaining patients in long-term psychiatric beds with the goal of identifying optimum treatment settings.

### Readjustment Counseling

Readjustment counseling is provided through a national system of 206 community-based counseling or Vet Centers. Vet Centers are located outside of the larger medical facilities, in easily accessible, consumer-oriented facilities highly responsive to the needs of the local veterans. The Vet Center program service mission features a holistic mix of direct counseling and multiple community-access functions: psychological counseling for veterans exposed to war trauma to include post-traumatic stress disorder (PTSD), and/or who were sexually assaulted during military service; family counseling when needed for the veteran's readjustment; community outreach and education; and extensive case management and referral activities. The latter activities include a full range of supportive social services designed to assist veterans improve general levels of post-military social and economic functioning. Eligibility for readjustment counseling at Vet Centers includes any veteran who served in the military in a theater of combat operations during any period of war, or in any area during a period in which armed hostilities occurred. For many veterans who would not otherwise receive VA assistance, the Vet Centers are the community access points for VA health care. Vet Centers also provide care to high-risk

## SPECIAL EMPHASIS PROGRAMS (CONTINUED)

### Readjustment Counseling (continued)

groups such as minorities, women, the disabled, high combat exposed, rural and homeless veterans. Comprising a unique non-medical VHA program, Vet Centers report to the Chief Readjustment Counseling Service (RCS) Officer at VA headquarters. Locally, the Vet Centers function in full partnership with the health care facilities in each of the 22 Veterans Integrated Service Networks (VISNs) to effect a well-coordinated spectrum of care for local veterans. For more information on Vet Centers, go to <http://vaww.va.gov/station/VetCenter/index.htm>.

### 2000 Achievement Highlights

- ◆ In 2000, the Vet Centers saw 131,358 total veterans and provided 896,236 visits to veterans and family members. This represents a 10 % increase in Vet Center visits from the previous year. Approximately 50,000 of the veterans served at Vet Centers were not seen in any other VHA facility. Vet Centers make over 100,000 referrals annually to VA medical facilities. In addition, the Vet Centers make over 120,000 referrals annually to VA Regional Offices, and over 115,000 referrals annually to non-VA community service providers.
- ◆ Veteran satisfaction continued at a high level for Vet Center services - 99% of veterans using Vet Centers in 2000 reported being satisfied with services received by responding yes that they would recommend the Vet Center to other veterans.
- ◆ Vet Center counselors and program managers provided on-site counseling, education regarding VA benefits and services, and other supportive assistance to veterans and family members upon the ceremonial occasions of the 50<sup>th</sup> anniversary of the onset of the Korean War and the ground breaking dedication for the World War II Memorial.
- ◆ Intervening with various elements in VA and the Department of Defense to compile the necessary evidence, in compliance with the law, RCS initiated the action necessary to authorize two new veteran groups for readjustment counseling at Vet Centers. Opening Vet Centers to approximately 180,000 veterans who served in the peace-keeping missions in Bosnia and Kosovo (May 2000). Extending Vet Center eligibility to approximately 80,000 Merchant Marines who served in seagoing duty during World War II (January 2001).
- ◆ The Readjustment Counseling Service in conjunction with Employee Education Service produced a video entitled “Tele-Health: Veterans’ Vital Link to Services” featuring the accomplishments of the Vet Center-Linked Primary Care project. The purpose of this project is to promote access to primary care for high-risk, hard-to-reach veterans closer to their respective communities through use of tele-medicine equipment in 20 Vet Centers. The video was distributed to all VHA medical facilities.

### Plans for 2001 - 2006

- ◆ Continue to enhance quality of care to veterans by further developing outcome measures for client satisfaction (e.g., quality of life measures) and veteran post-treatment functional status. Complete analysis of all available Vet Center client satisfaction surveys.
- ◆ Enhance the Vet Center program as a VA Employer of Choice. Further development of the “Vet Center of Excellence” initiative will provide a forum for continuous improvement to facilitate quality services and also to improve small team leadership, cooperation, and esprit de corps.
- ◆ RCS will fully participate in the Baldrige Award program to improve its organizational culture, program management, and service outcomes. In addition, RCS will be a full partner contributing to the VHA submission for the President’s Quality Award.
- ◆ The Vet Center program will make full use of its community-based service functions, in partnership with other VISN medical facilities, to promote VHA’s mission for building healthier communities.

## SPECIAL EMPHASIS PROGRAMS (CONTINUED)

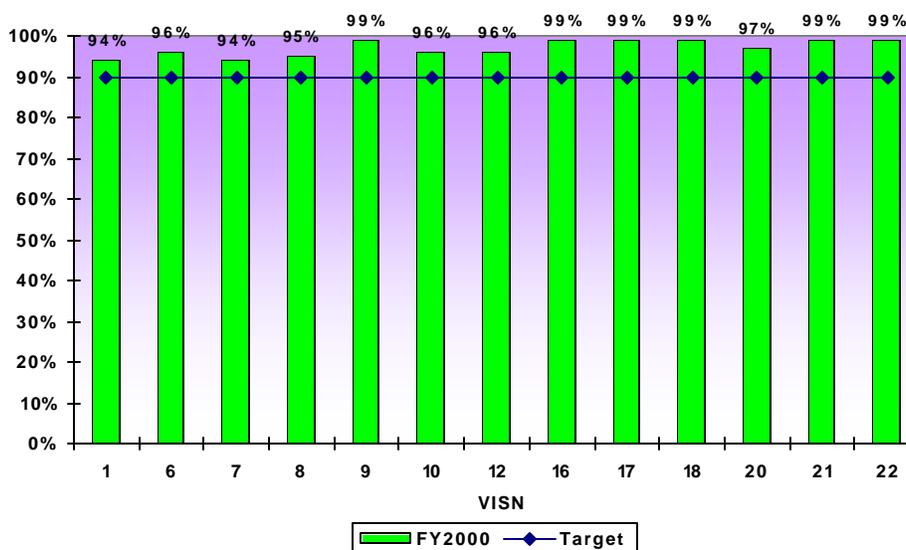
### Spinal Cord Injury and Disorders (SCI&D)

The SCI&D Program assists veterans with SCI&D to develop the capacities needed to attain personal independence and lifelong health and well being. This is accomplished by providing acute medical/surgical care, initial rehabilitation, preventive care, lifelong sustaining care, and lifelong rehabilitation across a continuum of inpatient and outpatient settings. These health and rehabilitative services are delivered through a “hub and spokes” spinal cord injury (SCI) system of care extending from the SCI Centers to SCI Outpatient Support Clinics and SCI Primary Care Teams and non-SCI Center facilities to improve access to care. SCI care is focused around the specialized expertise of interdisciplinary care teams within the 23 regional SCI Centers. Together they serve about 15,000 veterans. Acute rehabilitation services are provided to about 400 newly injured veterans and active duty personnel annually. For more information on SCI&D, go to <http://vaww.va.gov/health/sci/disorders>.

#### 2000 Achievement Highlights

- ◆ An external program review was completed indicating VHA provides comprehensive coverage for spinal cord injury through a uniquely organized system of care. “No other health care provider is similarly organized or as involved in the full continuum of care.”
- ◆ Seventy percent of VHA’s SCI programs providing acute rehabilitative care have achieved CARF accreditation. CARF accreditation has become increasingly important as an indication of commitment to meeting international standards of quality.
- ◆ A data system has been implemented to monitor the number of personnel assigned to some SCI care segments.
- ◆ An Intranet web tool has been released allowing SCI clinicians access to Spinal Cord Dysfunction Registry data on patients at other VHA facilities.

**Chart 3.2 Spinal Cord Injury Patients Discharged to a Non-Institutional Setting.**



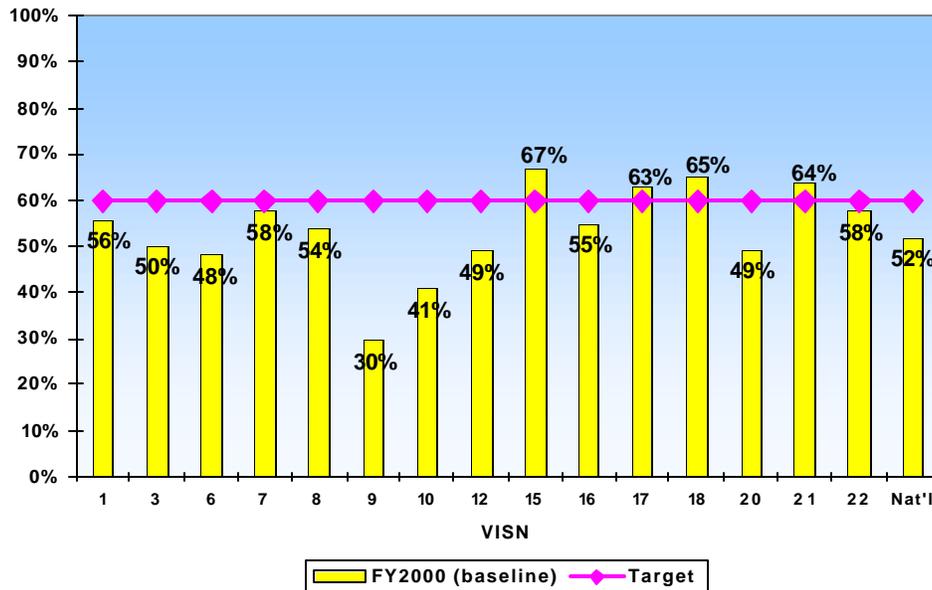
SOURCE: 2000 Network Performance Report

Note: VISN 3 and 15 did not have enough discharges for statistical reliability.

## SPECIAL EMPHASIS PROGRAMS (CONTINUED)

### Spinal Cord Injury and Disorders (SCI&D) (continued)

Chart 3.3 Spinal Cord Injury Patients Reporting Their Care as Very Good or Excellent.



SOURCE: 2000 Network Performance Report

#### Plans for 2001 - 2006

- ◆ The Spinal Cord Injury (SCI) Clinical Affairs Handbook, that serves as a national program guide, will be revised.
- ◆ A national VHA workgroup to study standards and staffing for SCI extended care, SCI outpatient settings, and acute SCI care nursing will forward recommendations to the Under Secretary for Health.
- ◆ Improvements will be made to an information and outcomes management system for spinal cord injury.

## SPECIAL EMPHASIS PROGRAMS (CONTINUED)

### Traumatic Brain Injury (TBI)

The TBI Network of Care provides case-managed, comprehensive, specialized rehabilitation spanning the period from discharge from the acute surgical treatment unit until permanent living arrangements can be made for patients with Traumatic Brain Injury. Arrangements are made at the highest, independent living level and are confirmed through follow-up. A significant number of these patients are referred to VA facilities from the military, and lead centers have been jointly established and cooperatively funded by DoD and VA to receive and screen all TBI patients and maintain a registry of these patients nationally. The Richmond (Network 6), Tampa (Network 8), Minneapolis (Network 13), and Palo Alto (Network 21) health care facilities have been designated as lead centers for this program. For more information about TBI, go to <http://vaww.va.gov/health/rehab>

#### 2000 Achievement Highlights

- ◆ Chief Network Officer appointed a Traumatic Brain Injury Strategic Workgroup to study and respond to the Office of Health Care Inspections comprehensive review of VHA's care of persons with traumatic brain injury. (Report Number 9HI-A28-199, June 30, 1999)
- ◆ Four of the six recommendations of the report have been satisfied.
- ◆ 68% of TBI patients in 2000 were discharged to the community.

#### Plans for 2001 - 2006

- ◆ Satisfy the recommendations made by the Office of Health Care Inspections (OHI) regarding VHA's care of persons with traumatic brain injury.
- ◆ Complete the system-wide survey of services and resources available at each medical center for TBI.
- ◆ Physical Medicine and Rehabilitation Strategic Healthcare Group and the Gainesville Brain Rehabilitation and Research Center are pursuing a proposal for funding the development of a VHA TBI Registry.

### Gulf War Veterans

The Gulf War Veterans Program provided strategic direction for the clinical, research, education and outreach programs for these veterans and ensures that available benefits are provided to eligible claimants. This is accomplished by working collaboratively with other VA offices; federal, state, and local government agencies; and, non-profit community and private providers. The Gulf War Veterans Program staff also serve as VHA's liaison to the Military Veterans Coordinating Board, an interagency organization co-chaired by the Secretaries of Veterans Affairs, Defense, and Health and Human Services. The ultimate goal is to ensure appropriate, quality health care for Gulf War Veterans. For more information on Gulf War Veterans, go to <http://vaww.va.gov/health/envIRON/persgulf.htm>.

#### 2000 Achievement Highlights

- ◆ Developed a request for proposals for two new Centers for the Study of War-Related Illnesses. These two new centers, funded annually at \$2.25M, are charged with developing new approaches to address the clinical, research, education, and outreach issues surrounding military and veteran health including the Gulf War.
- ◆ Developed draft Clinical Practice Guidelines for dealing with health problems of newly returning veterans from U.S. combat and peace-keeping missions abroad.

## SPECIAL EMPHASIS PROGRAMS (CONTINUED)

### Gulf War Veterans (continued)

#### 2000 Achievement Highlights

- ◆ Received the first report from the National Academy of Sciences Institute of Medicine on Gulf War and Health, and initiated a second report on the scientific literature on Gulf War risk factors. These reports are the key component for establishing presumptive compensation policy for health effects that may be due to wartime environmental exposures.

#### Plans for 2001 - 2006

- ◆ Work to disseminate new and novel approaches to treatment of Gulf War veteran illnesses that are developed by VA clinicians and researchers to the VA medical community at large.
- ◆ Establish at least two national Centers for the Study of War-Related Illnesses. These new centers will build upon lessons learned from the Gulf War, and develop new approaches to provide treatment, education, research, and outreach for veterans from all U.S. deployments and their families.
- ◆ Continue development on a series of Clinical Practice Guidelines to provide VA clinicians with the tools they need to address the health concerns of Gulf War veterans.
- ◆ Significantly enhance and expand outreach to Gulf War veterans and their families on VA health care, compensation, Gulf War related research and other issues. This will primarily be carried out through enhancing existing website, newsletters, and other related media to get the word out to veterans.

### Women Veterans

VHA Women Veterans Health Program ensures the integration of clinical care, education, outreach, and research to improve the utilization of VHA health care programs by women veterans. For more information, go to <http://vaww.sites.lrn.va.gov/vvhp>.

#### 2000 Achievement Highlights

- ◆ Wyeth – Ayerst 2000 HERA Bronze Winner Award Recipient.
- ◆ Conducted Women Veterans Program Manager model pilot in VISNs 4 & 9.
- ◆ Awarded the First Annual Women Veteran Coordinators of the New Millennium Award.
- ◆ Convened Women Veterans Health National Strategic Work Group.
- ◆ Hosted the Fourth Annual Women Veterans Health Clinical Update.
- ◆ Lead Women Veterans Coordinators appointed in all Networks.
- ◆ Developed Military Sexual Trauma implementation guide and Sexual Trauma Directive.
- ◆ Submitted reports on sexual trauma program to Congress.
- ◆ Validated and updated the 1999 Women Veterans Patient Privacy Survey.

## SPECIAL EMPHASIS PROGRAMS (CONTINUED)

### Women Veterans (continued)

#### Plans for 2001 - 2006

##### Where the program will be in five years

- ◆ The health care provider of choice for women veterans exceeding the patients' expectations.
- ◆ Promote cooperation and collaboration throughout VA in order to provide One VA seamless health care to women.
- ◆ Utilize state-of-the-art women's health products, equipment, and technologies.
- ◆ Serve as leaders in the health care industry in the delivery of services to women.
- ◆ Exceeding Healthy People 2010 women's health performance goals.
- ◆ Increase market diversity of minority women and women with disabilities.

##### We will get there by

- ◆ Conducting a comprehensive study on the current status of the VHA Women Veterans Health Program.
- ◆ Developing women's health clinical practice guidelines.
- ◆ Developing standardized national clinical performance standards and administrative guidelines.
- ◆ Collaborating with VSO, VHA, VBA, NCA, DoD, and CWV stakeholders.
- ◆ Promoting aggressive women veterans marketing and outreach efforts.
- ◆ Providing patient and provider education, training, and consultation.
- ◆ Standardizing women's health data collection and reliability.
- ◆ Encouraging women's health research and pilot demonstration projects.
- ◆ Rewarding programs and staff for excellence and innovation.

##### We will know we're there by

- ◆ Monitoring clinical performance/outcome trends.
- ◆ Improving veteran service satisfaction and utilization rates.
- ◆ Monitoring resource allocation and utilization trends.
- ◆ Implementation of efficient and reliable data management systems.



Figure 3.1 Women Air Force Service Pilots (WASPs) from World War II.

## SPECIAL EMPHASIS PROGRAMS (CONTINUED)

### Blind Rehabilitation

Blind Rehabilitation Service provides services to eligible veterans who meet the definition of legal blindness (a person's best corrected visual acuity in the better eye is less than or equal to 20/200, or if the central visual acuity in that eye is better than 20/200, the visual field is less than or equal to 20 degrees in the widest diameter). The Service is dedicated to improving the quality of life for blinded veterans by assisting them to develop the skills and capabilities needed to attain personal independence and emotional stability. The Service accomplishes this goal through identification of visually impaired veterans, provision of comprehensive inpatient and outpatient rehabilitation services, education of blinded veterans and their families, and on-going research. Research is conducted by research personnel at three of the Blind Rehabilitation Centers. Research is also conducted by the Rehabilitation Research and Development Center at VAMC Decatur. For more information on Blind Rehabilitation Service, go to <http://vaww.va.gov/blindrehab>.

#### 2000 Achievement Highlights

- ◆ An Orientation and Mobility Section team at the Western Blind Rehabilitation Center in the VA Palo Alto Health Care System received the 2000 Olin E. Teague Award for developing the first training program for low-vision/blind veterans with ambulatory problems integrated into a standard blind rehabilitation program.
- ◆ CARF accreditation (3 years) of Eastern Blind Rehabilitation Center, VA Connecticut Health Care System, West Haven Division. (July 2000)
- ◆ Activation of new 15 bed Blind Rehabilitation Center, VAMC West Palm Beach, FL. (June 2000)
- ◆ Three-year Outcomes Research project completed. Demographic data on over 4,000 blinded veterans.
- ◆ Research funding for new expanded Outcomes Research project which will incorporate Blind Rehabilitation Center, VIST Coordinator, and BROS data.
- ◆ 3 new Blind Rehabilitation Outpatient Specialist positions established at VAMCs Waco and West Palm Beach.
- ◆ National VIST/ BROS training conference held in conjunction with Blinded Veterans Association Convention. (August 2000)

#### Plans for 2001 - 2006

- ◆ Obtain CARF accreditation for all Blind Rehabilitation Center programs.
- ◆ Expand Blind Rehabilitation Outpatient Specialist (BROS) Program.
- ◆ Completion of national database software package for Blind Rehabilitation Centers, Visual Impairment Services Team (VIST), and BROS.
- ◆ Expansion of Outcomes Measurement Project.
- ◆ Joint Blind Rehabilitation Service/Prosthetics and Sensory Aids SHG national meeting.
- ◆ Development of protocol for evaluation of assistive technologies by Blind Rehabilitation Centers.
- ◆ Development of clinical pathways/algorithms for the national program.

## SPECIAL EMPHASIS PROGRAMS (CONTINUED)

### Preservation/Amputation Care and Treatment (PACT)

The PACT program is focused on reducing the incidence of amputations and other complications due to diabetic foot ulcers and peripheral vascular disease. An interdisciplinary program of care and treatment is provided to patients. Patients with amputations and those identified as at risk for limb loss are tracked and monitored. For more information about PACT, go to <http://vaww.va.gov/health/rehab>.

#### 2000 Achievement Highlights

- ◆ 78% of amputee patients treatment in rehabilitation bed settings were discharged to a community setting (home, board and care, transitional living, or assisted living). This represents a 2% improvement over 1999 data.
- ◆ 87% of diabetic patients screened for foot problems and identified as “at risk” for amputation were referred to a foot care specialist. This represents a 1% gain over 1999 data.

#### Plans for 2001 - 2006

- ◆ Review and update VHA Directive 96-007 to increase emphasis on prevention.
- ◆ Complete CD-ROM on the Preservation/Amputation Care and Treatment Program to educate and train primary care staff and other clinicians in screening and recognition of foot problems in the diabetic population and subsequent referral to a foot care specialist.
- ◆ Increase the number of amputee patients whose rehabilitation outcomes data are entered into the Functional Status and Outcomes Database (FSOD) by expanding the data collection across the full continuum of rehabilitative care without respect to the treatment setting.



**VISN**  
**Highlight**  
VISN 3  
Strategic Plan  
2001-2006

#### **Coordination and Follow-up in the Preservation/Amputation Care and Treatment (PACT) Program**

The Physical Medicine and Rehabilitation Service (PM&R) of the Harbor Health Care System (HCS) and the Network Prosthetics Service assist in the coordination and patient follow-up for all activities in the PACT program. This team identifies current amputees and other veterans, generally diabetic and vascular that may be at potential risk for amputation from the VISTA database or by referral from other clinics. PACT conducts regularly scheduled clinics, education classes on proper foot care, and follows up on all identified patients depending on their classified level of risk for amputation. Presently, the Harbor HCS has 350 patients enrolled in this program.

### Prosthetics and Sensory Aids

Prosthetics and Sensory Aids Service Strategic Healthcare Group (PSAS) furnishes prescribed prosthetic equipment, sensory aids and devices to eligible disabled veterans in the most economical and timely manner in accordance with authorizing laws, regulations, and policies. PSAS also serves as case manager for the physically disabled veteran to provide quality prosthetic and sensory aids services. The objectives of PSAS are to restore the capability of disabled veterans to the greatest extent possible, improve their quality of life, and to continually assess veterans' satisfaction with VA-prescribed prosthetic and sensory aids.

## SPECIAL EMPHASIS PROGRAMS (CONTINUED)

### Prosthetics and Sensory Aids (continued)

#### 2000 Achievement Highlights

- ◆ Recipient of Scissors Award – Home Oxygen Software Program.
- ◆ Revision of the Home Respiratory Care Program Directive.
- ◆ Computerized-Leg Interim Prescription Guidelines.
- ◆ Updated the Prosthetic and Sensory Aids Service Operations Manual, i.e., VHA Directive 1173 and VHA Handbooks 1173.1 – 1173.15.
- ◆ Reissued Directive on Reimbursable Amounts for Automobile Adaptive Equipment.

#### Plans for 2001 - 2006

- ◆ Implementation of the first National Prosthetic Inventory Report.
- ◆ Enhancements to the National Prosthetic Patient Database.
- ◆ Establishment of a comprehensive Prosthetic Clinical Management Program that will focus on prescription policies and new contracting initiatives.

## HEPATITIS C

Hepatitis C Virus (HCV) is a blood-borne viral infection that was first recognized in the 1970s. The virus that causes hepatitis C was identified in 1992 and reliable tests were developed for patient and blood screening shortly afterwards. Hepatitis C infection is now recognized as a serious national public health problem. Nearly 4 million Americans are believed to be infected and approximately 30,000 new infections occur annually. Data indicates the prevalence of hepatitis C among veterans who use VHA services may be significantly higher than the national prevalence and that Vietnam era veterans may be at higher risk. If this is the case, given the long period of time it takes for hepatitis C to become clinically apparent, a dramatic increase in end-stage liver disease resulting from hepatitis C may be seen. Thus proactive education, screening, testing, and treatment programs have been implemented.

#### 2000 Achievement Highlights

- ◆ Continued support for two Centers of Excellence for Hepatitis C in Miami, FL and San Francisco, CA which have:
  - ▲ Developed clinical practice guidelines for diagnosis and treatment of HCV infection.
  - ▲ Conducted national staff education programs including national symposia and local grand rounds in 39 clinical facilities, bringing experts in hepatitis C care to the local hospitals and clinics where care is provided.
  - ▲ Developed a broad array of patient education materials.
  - ▲ Conducted clinical research.
  - ▲ Developed a web site for patient and provider oriented information, with major upgrades planned for early 2001.
- ◆ Launched a cooperative study involving 28 VA medical centers which will help to determine the answers to important epidemiologic, pathogenesis, and treatment outcome questions.

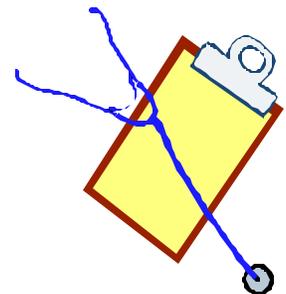
## HEPATITIS C (CONTINUED)

### 2000 Achievement Highlights

- ◆ Distributed \$20 million to the 22 VISNs specifically for outreach, testing, counseling, and treatment of hepatitis C.
- ◆ Distributed and mandated implementation of the new VISTA clinical reminder software patch to facilitate the documentation and tracking of screening for hepatitis C risk factors.
- ◆ Implemented new VERA reimbursement definitions that classify patients on treatment for hepatitis C at the complex level. This change will support and encourage treatment with costly and difficult regimens as well as disparities in resource needs created by geographic variation in hepatitis C prevalence.
- ◆ Under Secretary for Health transferred responsibility for VHA's hepatitis C programs to the Office of Public Health and Environmental Hazards (13). This was done to develop and implement a public health approach to VA's hepatitis C programs and in recognition that hepatitis C is a major chronic medical and public health issue for VHA.

### Plans for 2001 - 2006

- ◆ Fully implement a comprehensive national hepatitis C program under the leadership of a new strategic healthcare group. By the end of 2001, this program will be fully staffed and funded to accomplish the important task of making the VHA a national leader in hepatitis C clinical care, prevention, and research. The major components of this program will include:
  - ▲ Veterans Hepatitis C Awareness Program which will aggressively work within VA and with external groups to improve awareness about hepatitis C among veterans.
  - ▲ Hepatitis C Care Program which will deliver the highest standard of care to veterans with hepatitis C.
  - ▲ Hepatitis C Clinician Education Program that will insure all VA clinicians are provided the most up-to-date scientific information about hepatitis C in order to deliver the highest quality care to veterans with hepatitis C, as well as to assist those at risk to prevent becoming infected with the virus that causes hepatitis C.
  - ▲ Hepatitis C Screening, Testing and Counseling Program which will provide multiple avenues of access to veterans who wish to be tested for hepatitis C.
  - ▲ Hepatitis C Prevention Program which will work with various parts of VHA to identify veterans who may be at risk acquiring hepatitis C and to offer risk reduction and prevention interventions.
  - ▲ Hepatitis C Quality Management and Database Program which will work with existing VA data systems to collect and analyze quantitative data on hepatitis C as well as utilization and quality parameters in order to continually improve hepatitis C care and prevention in VHA.
- ◆ Complete a recompetition for national Centers of Excellence in Hepatitis C with five-year funding to commence in 2002. The support of the Centers will catalyze the creation of innovative clinical and research programs which are field based and of direct relevance to care providers.
- ◆ Continue to build on existing partnerships with Veteran Service Organizations, advocacy groups and industry to create heightened awareness of the importance of hepatitis C in veteran populations, the need for better tolerated and more effective treatments, and to assure input from all stakeholders in the processes of care delivery.
- ◆ Develop and implement data systems which facilitate collection of information regarding the prevalence of hepatitis C infection in served populations, the effectiveness of screening and testing programs, the outcomes of care, and the consistency of compliance with guidelines and standards of care. This will include the creation of a national electronic registry of hepatitis C infected patients to be implemented and maintained by the Hepatitis C Quality Management and Database Program.



## HEPATITIS C (CONTINUED)

### Plans for 2001 - 2006

- ◆ Improve and facilitate the process of cross communication between program leadership, field-based clinicians and technical experts by conducting a series of regional think-tank conferences during the winter and spring of 2001, and the creation of a permanent Technical Advisory Group which will provide both information and advice to program leadership.
- ◆ Implement fully the goal contained in the Under Secretary's Information Letter (IL 10-98-013) to screen all veterans who utilize VA medical services for risk factors associated with hepatitis C infection, to document this screening in the medical record, and to conduct diagnostic testing based on the presence of risk factors.

## NATIONAL CENTER FOR ETHICS

The National Center for Ethics is VHA's primary office for addressing the complex ethical issues that arise in patient care, health care management, and research. Founded in 1991, the Center is a field-based national program that is administratively located in the Office of the Under Secretary for Health. The main office of the Center is located in White River Junction, VT.

The Center's mission is to clarify and promote ethical health care practices within VHA and throughout the country. The Center serves as the principal advisor on ethical issues to the Under Secretary for Health. For more information on the national center, go to <http://vaww.va.gov/vhaethics>.

### 2000 Achievement Highlights

- ◆ Publication of *Challenges and Change*, a collection of 14 VHA National Ethics Committee reports.
- ◆ Design and development of a newsletter, "news@vhaethics."
- ◆ Highly acclaimed national training program, "Intensive Ethics Training: Knowledge and Skills for an Effective Ethics Program."

### Plans for 2001 - 2006

- ◆ Improve the effectiveness of integrated ethics programs at national, regional, and local levels.
- ◆ Develop methods for measuring and improving the ethical quality of VHA health care.
- ◆ Create multi-media communication and networking tools to promote knowledge and discussion of pressing ethics issues system-wide.

## Chapter 4: Millennium Bill

The President signed the “Veterans Millennium Health Care and Benefits Act” on November 30, 1999. The Act included significant new authorities that impact veterans medical programs. Major provisions include expansion of eligibility for VA nursing home care; expansion of home based and community based care options; new co-pays for extended care services; authority for VA to conduct an assisted living pilot program and three all-inclusive long-term care pilot programs; expanded coverage of emergency services; enhanced eligibility for combat injured (Purple Heart Award) veterans; expanded authority for VA to treat TRICARE enrollees; expansion of specialized mental health services; expansion of sexual trauma counseling authority; authority for the Secretary to set the pharmacy and outpatient co-pays; expanded chiropractic services for veterans; and modification of the process for prioritizing grants for construction of state home facilities.



This chapter highlights the following regarding the Millennium Bill:

- Geriatrics and Long Term Care (LTC).
- Homeless Program.
- Emergency Care.
- Chiropractic Care.
- Sexual Trauma Counseling.
- Enhanced-Use Leasing Authority.

### GERIATRICS AND LONG TERM CARE (LTC)

Over the next 21 years, the veteran population will decline nearly 35% (assuming no major-armed conflicts). At the same time, the percent of veterans over the age of 65 will decline only by 12% while those over 85 will increase by 333%. The number of veterans over age 65 was expected to peak at 9.3 million in the year 2000, when 66% of all American males aged 65 and over will be veterans. A second but smaller peak is expected to occur in 2015, with the aging of the Vietnam War-era veterans. The general U.S. population is expected to peak in the year 2030. Of note, the number of very old veterans, i.e., those who are age 85 and over, will continue to increase until 2013. Thus, the “demographic imperative” that VHA faces will not confront the American society as a whole for another 15 to 20 years (i.e., the burgeoning population of elderly persons needing both acute and long-term health care services). Currently, 38% of the veteran population is over 65 vs. 13% of the total U.S. population. Over 51% of veterans who have service connected disabilities and/or who are poor are over 65 (91% of current VA enrollees have service connected disabilities and/or are poor).

#### 2000 Achievement Highlights

- ◆ In February 2000, the Deputy Under Secretary for Health convened a Task Force, co-chaired by the Assistant Deputy Under Secretary for Health and the Chief Consultant, Geriatrics and Extended Care, and charged them to fully develop a plan and strategy for implementation of the statutory requirements related to long-term care and to expedite compliance with congressional direction and provision of services required by our nation’s veterans. Seven workgroups were formed.
- ◆ Implemented mandatory nursing home care for veterans in need of nursing home care for a service connected disability, and for any condition of a 70% or greater service connected veteran through policy directives 2000-007 and 2000-044.

## GERIATRICS AND LONG TERM CARE (CONTINUED)

### 2000 Achievement Highlights

- ◆ The following was developed by the Provision of Care Workgroup:
  - ▲ Consistent set of definitions for extended care services that are in use throughout VHA for planning, budgeting, and clinical care.
  - ▲ An overall model/approach to the LTC patient that is patient-focused and coordinates care throughout the acute, outpatient, community, and extended care continuum.
  - ▲ Drafted regulations to amend the existing medical benefits package to include adult day health care, geriatric evaluation, and respite care.
- ◆ LTC Co-Payment Workgroup drafted detailed co-payment regulations with assistance from PricewaterhouseCoopers who conducted a review of Medicare, state, and private insurance co-payment levels.
- ◆ Pilots Workgroup:
  - ▲ Requests for Proposals (RFP) for the pilots were developed and disseminated to all VA facilities.
  - ▲ 22 full proposals for the three Long-Term Care Pilots were reviewed by a Merit Review Panel and the final selections were submitted to the Under Secretary for Health for approval.
  - ▲ 13 full proposals for the one Assisted Living Pilot were reviewed by a Merit Review Panel and the final selection was submitted to the Under Secretary for Health for approval.
  - ▲ VA Health Services Research and Development teams were selected to conduct the evaluation of the pilots.
- ◆ The following was developed by the State Home Workgroup:
  - ▲ Drafted regulations that specified changes in priorities for awarding State Home Construction Grants and criteria for determining state need for beds.
  - ▲ Developed a transition priority list of pending 1999 priority 1 projects to guide the construction grant funding for 2001.

### Plans for 2001 - 2006

- ◆ Publish Final Regulations in the Federal Register for affected extended care services.
- ◆ Develop final policies and operational procedures.
- ◆ Analysis of how the Millennium Act has affected current practices in admission and discharge to VA Nursing Home Care Units (NHCUs), focusing on trends over time.
- ◆ Select the Long-Term Care Pilot sites with initiation of three-year pilot program in April 2001.
- ◆ Finalize a detailed evaluation plan regarding costs and cost avoidance related to provision of extended care under the Millennium Act, initiate data collection, provide first accountability reports by the end of 2001.
- ◆ Develop baseline measures for extended care services (e.g., hospice care) that were not separately coded in 1998.
- ◆ Select the Assisted Living Pilot site with initiation of the three-year pilot program in April 2001.



## HOMELESS PROGRAMS

The Millennium Act impacts VA's homeless veterans programs. In the first place, it extends program authority for the Homeless Providers Grant and Per Diem Programs. This section also removes the limit on the number of vans that can be purchased with funding made available by VA under the grant component of the program. Secondly, the Act requires VA to provide a detailed plan to evaluate the long-term effectiveness of VA's programs to assist homeless veterans. The plan is required to include housing and employment outcome measures and to be prepared in consultation with the Secretary of Housing and Urban Development (HUD), and the Secretary of Labor (DoL).

### 2000 Achievement Highlights

- ◆ New authority was published as a Notice of Funding Availability (NOFA) in the Federal Register (April 2000) for grants to non-VA organizations to develop supported housing programs for homeless veterans, supportive service centers for homeless veterans, and vans to conduct outreach and provide transportation for homeless veterans.
  - ▲ Of the 131 applications received, 65 were awarded grants totaling \$11.5 million.
    - 65 projects in 26 states and the District of Columbia that, when fully operational, will make 955 new community based beds available for homeless veterans.
    - \$969,965 was awarded to 38 organizations to support the purchase of 49 vans.
    - \$10,498,034 was awarded to support the development of 27 supported housing programs and purchase 16 vans.
- ◆ VA's Evaluation Plan:
  - ▲ Identifies homeless veterans in existing programs at selected sites to serve as historical controls.
  - ▲ Introduces innovative treatment models that have been used to treat non-veterans in the private sector. Veterans receiving treatment in these innovative programs are also enrolled in the evaluation study.
  - ▲ Homeless veterans in existing programs and those involved in innovative treatment programs will, to the extent possible, be followed for one year after discharge from the treatment programs.

### Plans for 2001 - 2006

- ◆ Assess the need to support the development of additional supported housing projects, supported service centers, and/or the purchase of vans under the Grant and Per Diem Program.
- ◆ Implementation of VA's long-term evaluation of homeless veterans programs which is a five-year study with progress reports every two years.



**VISN  
Highlight**  
VISN 6  
Strategic Plan  
2001-2006

#### Veterans Only Oxford Houses

The VISN Homeless Veterans Coordinator, working with the Mental Health Service Line leadership, has aggressively pursued programs to support the growing homeless population. Plans for succeeding years incorporate services to homeless veterans including 1) increased outreach and access to transitional housing in collaboration with local community homeless coalitions, 2) expansion of intensive case management, 3) expansion of veterans only Oxford Houses in each city in the VISN, 4) Compensated Work Therapy programs for homeless veterans or those at risk for homelessness at every site, and 5) expansion of services to homeless women veterans.

## EMERGENCY CARE

Under the Veterans' Millennium Health Care Act, veterans who are eligible for reimbursement of emergency services at non-VA facilities are defined as individuals who are active Department health care participants who are enrolled in the health care system and have received care within the 24-month period preceding the furnishing of such emergency treatment. Veterans who have insurance coverage, entitlement to care from any other Department or Agency of the United States (Medicare, Medicaid, TRICARE, Workers Compensation, etc.) or have other contractual or legal recourse would not be eligible for reimbursement. VA would be the payer of last resort. The Secretary has the prerogative to establish maximum reimbursement amounts and circumstances for provision of emergency care under this Act.

The Act defines "emergency treatment" as medical care or services furnished: 1) when Department or other Federal facilities are not feasibly available and an attempt to use them beforehand would not be reasonable; 2) when such care or services are rendered in a medical emergency of such nature that a prudent layperson reasonably expects that delay in seeking immediate medical attention would be hazardous to life or health; and 3) until such time as the veteran can be transferred safely to a Department facility or other Federal facility.

The Millennium Act made the new emergency care provisions effective on May 29, 2000 and the Secretary has determined that VA will pay for qualifying emergency care rendered in non-VA facilities on or after that date. However, VA cannot make actual payment for the care until after the final regulations are published in the Federal Register, a process that may take a considerable length of time (possibly as late as Fall 2001). VA will, therefore, make payments retroactively to May 29, 2000 after the final regulations are issued. Claims for emergency care provided at non-VA facilities are being held in anticipation of published regulations.

### 2000 Achievement Highlights

- ◆ Interim Guidance (IL 10-2000-005) issued to field on 7/20/00.
- ◆ Submitted proposed regulations to Office of Management and Budget.
- ◆ An Emergency Care Work group, comprised of field and headquarters clinical and administrative staff, met throughout the year. They presented their recommendations to the Policy Board and the Under Secretary for Health on June 8, 2000.

### Plans for 2001 - 2006

- ◆ Publish Final Regulation in Federal Register.
- ◆ Develop final policies and operational procedures.
- ◆ Establish centralized claims processing center for all emergency care bills.



## CHIROPRACTIC TREATMENT

The Millennium Act required the Under Secretary for Health to establish a VHA-wide policy regarding the use of chiropractic treatment in the care of veterans following consultation with chiropractors. The law specifically defined “chiropractor” and “chiropractic treatment,” limiting treatment to manual manipulation of the spine for musculoskeletal conditions.

### 2000 Achievement Highlights

- ◆ Meeting held between VHA and eight chiropractic organizations.
- ◆ VHA reviewed literature from chiropractic organizations, from scientific peer-reviewed literature on the treatment of back pain and the use of chiropractic services, from Medicare, and from the recent DoD feasibility study.
- ◆ VHA Policy issued in May 2000 regarding chiropractic care to veterans.
- ◆ Network/Facility polices were developed.
- ◆ Developed patient education brochure on chiropractic services in VA and distributed the electronic template to VISNs for their use.
- ◆ Implemented changes to Central and Local Fee payment files to include “chiropractor” as a provider type.
- ◆ VHA paid for over 9,700 chiropractic visits for veterans in 2000.

### Plans for 2001 - 2006

- ◆ Development of “Chiropractic” as a clinic type.
- ◆ Review of network and facility-specific policies for conformance to the national policy.
- ◆ Formulate action plan from review and analysis.
- ◆ Explore possibilities to conduct outcomes research related to spinal manipulative therapy and chiropractic care.
- ◆ Conduct further meetings with chiropractors and chiropractic professional organizations.
- ◆ Review, analyze, and trend data from the fee files on use of chiropractic services on a quarterly basis.
- ◆ Develop liaison with DoD to learn from DoD implementation of chiropractic services and to explore development of joint service provision.

## SEXUAL TRAUMA COUNSELING

The Millennium Act extends the program authority and makes the provision of sexual trauma counseling services mandatory through 2004. This section also requires a joint VA/DoD study and report to Congress regarding the implications of expanding eligibility to provide sexual trauma counseling services to former members of the Reserve components of the Armed Forces and requires reports to Congress regarding VA/DoD sexual trauma counseling outreach efforts, program oversight, and implementation activities.

### 2000 Achievement Highlights

- ◆ New authority implemented by VHA Directive 2000-008 (February 2000).
- ◆ Report on outreach was completed and submitted to Congress (August 2000).
- ◆ Report on oversight was completed and submitted to Congress (February 2001).
- ◆ Report on implementation was completed and is undergoing concurrence review processes.

## SEXUAL TRAUMA COUNSELING (CONTINUED)

### 2000 Achievement Highlights

- ◆ Interim report on the study on implications of expanding eligibility to former Reservists of the Armed Forces was completed and is undergoing concurrence review processes.

### Plans for 2001 - 2006

- ◆ Develop a proposal to study the implications of expanding eligibility to former Reservists of the Armed Forces.
- ◆ Submit reports on oversight and implementation once concurred with by respective Secretaries.

## ENHANCED-USE LEASING AUTHORITY

The Millennium Act expanded the Department's authority to enter into enhanced-use leases in several important areas. First it will now allow a lease when it results in demonstrable increases in services to eligible veterans in addition to the prior authority that focused on enhancing specific Department activities on the leased premises. In addition to prolonging the program's authority to December 31, 2011, it also extended the duration of authorized enhanced-use leases to 75 years, allowed the use of minor construction monies for capital contribution to such leases, and enabled VA to direct enhanced-use lease proceeds into medical care accounts. Lastly, the act mandated that VA undertake training and outreach efforts to field personnel and that VA undertake an independent study of potential enhanced-use opportunities nationwide.

### 2000 Achievement Highlights

- ◆ Expanded authority implemented by VA Directive 7415.1 (March 2000).
  - ▲ Incorporated expanded authority into enhanced-use leasing initiatives. Examples include:
    - Assisted living house for veterans in Montrose, NY and Bedford, MA.
    - Transitional housing for homeless veterans in Canandaigua, NY; Bedford, MA; and Barbers Point, HI.
    - VBA Regional Office collocations in Albuquerque, NM; Milwaukee, WI; and Las Vegas, NV.
    - Nursing facilities in Menlo Park, CA.
  - ▲ Allowed net revenues from enhanced-use leases to be deposited in and obligated from the Health Services Improvement Fund.
  - ▲ Included enhanced-use leasing authority in its capital asset management training sessions for Headquarters, network, and field personnel.
- ◆ Held Department's first national asset management conference (June 2000).
- ◆ Included enhanced-use leasing authority in VHA's CARES Initiative.

### Plans for 2001 - 2006

- ◆ Review of enhanced-use leasing initiatives will be incorporated into the Department's CARES initiative.

## Chapter 5: Academic Affiliations, Research, & Emergency Management

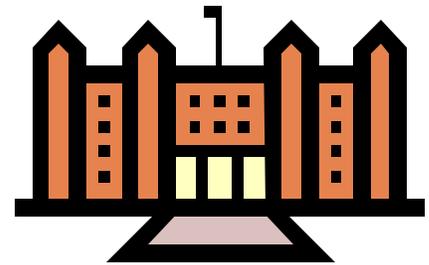
Although the primary mission of the Veterans Health Administration (VHA) is to serve the health care needs of American veterans, there are three other statutory missions – education, research, and Department of Defense (DoD) back up. VHA is extensively involved in the nationwide training of physicians, medical residents, and associated health professionals and in conducting medical research that greatly enhances the quality of care provided to veterans within the VA system, as well as enhances the level of American health care in general. The training of future health professionals determines in large measure how health care will be provided in the future. The VA health care system plays a substantial role in improving future health care delivery modalities and quality of care by investing in the training and research activities of its health care professionals. VHA also has a mission to provide contingency support to DoD and the Public Health Service during times of disaster or national emergency, and is one of the government’s principal assets for responding with medical assistance to large-scale national emergencies.

This chapter highlights and forecasts for the following:

- Academic Affiliations.
- Research.
- Emergency Management.

### ACADEMIC AFFILIATIONS

VHA conducts education and training programs to enhance the quality of care provided to veterans within the VA health care system. Efforts are accomplished through partnerships with affiliated academic institutions. Building on the long-standing and close relationships between VA and the Nation’s academic institutions, VA plays a leadership role in defining the education of future health care professionals to help meet the rapidly changing needs of the Nation’s health care delivery system. Today, more than 150 VA facilities have affiliations with 107 medical schools, 55 dental schools and more than 1,200 other schools across the country. More than half the physicians practicing in the United States have had part of their professional education in the VA health care system. Additionally, VA doctors conduct hundreds of research studies in conjunction with their facilities’ affiliated medical schools.



For the education mission, VHA’s change strategy has emphasized alignment of excellent patient care with training of future health professionals. In this regard, VHA has provided important leadership for its academic partners during these times of great change throughout all of health care.

## ACADEMIC AFFILIATIONS (CONTINUED)

### 2000 Achievement Highlights

- ◆ Published report July 2000: *VA's Commitment to Health Care Through Post-Residency Special Fellowships Education.*
- ◆ Published report July 2000: *Facility Education Infrastructure Assessment: Associate Chief of Staff for Education Positions.*
- ◆ Restructured VHA's participation in graduate medical education by decreasing involvement in more specialized residency training programs and increasing generalist residency training programs. Accordingly, VHA has replaced 1,000 specialty resident positions with 750 generalist positions and realigned VHA's graduate medical education from 38% to 48% in primary care.
- ◆ Enhanced VHA's support of Pain as the Fifth Vital Sign by selecting nine VA facilities to support medical residency training in Anesthesiology Pain Management.
- ◆ Enhanced VHA's support of treatment for addiction and dual diagnosis disorders by selecting nine VA facilities to support medical residency training in Addiction Psychiatry.
- ◆ Completed a two-year initiative to focus greater attention to training of resident physicians in end-of-life care. Funded in part through a grant of nearly \$1 million from the Robert Wood Johnson Foundation, the project developed curricula for the care of patients through the end-of-life. The curricula was integrated into affiliated internal medicine residency training programs at 30 competitively selected VA sites. The project also raised the visibility of VA in the field of palliative medicine, and contributed to VA's ongoing efforts to advance excellent end-of-life care for our nation's veterans.
- ◆ The Resident Orientation Pocket Card and website have become part of the orientation of medical and allied health students and residents to VA medical facilities. The initiative reflects a commitment to making the veteran patient aware that unique experiences as a veteran are of concern to VA clinicians. The card suggests opportunities to invite the veteran to tell his or her own story while the website provides the student or resident with information that will offer greater insight into the veterans story.

### Plans for 2001 - 2006

- ◆ VHA's Learners Perception Survey: The first system-wide survey of medical residents and other clinical trainees will be conducted and the results of the survey will be used to implement targeted improvements to benefit both learners and veteran patients in VA.
- ◆ Strategic initiatives targeted to veterans health care needs with the development of Special Fellowship Programs in:
  - ▲ Advanced Geriatrics.
  - ▲ Advanced Psychiatry and Psychology.
  - ▲ Advanced Spinal Cord Injury Medicine.
  - ▲ Parkinson's Disease.
  - ▲ Interprofessional Palliative Care.
  - ▲ Patient Safety.

## RESEARCH

As VHA continues its historical transformation, the Office of Research and Development maintains its dedication to its mission of discovering knowledge and creating innovations that advance the health and care of veterans and the Nation. The office aspires to lead VHA in providing unequaled health care value to veterans. That endeavor is made ever greater and challenging by the changing dynamics of health care, which is always evolving as consumers demand quality for their dollar, and medical technology leaps ahead of the capacity to manage it. The Office of Research and Development is like a major “wheel” of research, and the office’s four Services are its “spokes.” The *Cooperative Studies Program* applies knowledge through multi-center clinical trials of new therapies. *Health Services Research and Development Service* improves the effectiveness and efficiency of health care. *Medical Research Service* studies fundamental biological processes to increase understanding of disease pathology, diagnosis, and treatment. *Rehabilitation Research and Development* works to minimize disability and restore function in patients disabled by trauma or disease. The estimated total research funding (both VA and non-VA) for 2000 is approximately \$1.146 billion.



Each of the divisions has particular areas of expertise that increasingly cross the once-traditional boundaries to combine efforts and resources to achieve greater success. In addition, the research program seeks to translate that knowledge into practice by ensuring that new information is quickly made available to those who deliver care.

### 2000 Achievement Highlights

- ◆ Published *Impacts 2000*, a document that highlights some of VA’s recent accomplishments in each of the four services. (April 2000)

#### Medical Research Service

- ◆ *Age-associated memory loss may be reversible.* A VA team and colleagues have identified a process by which the normal primate brain degenerates with aging and showed that this degeneration can be reversed by gene therapy. In addition, the findings may offer a new approach against the cognitive decline in conditions such as Alzheimer’s disease.
- ◆ *Inherited genetic variants from both parents increases risk of Alzheimer’s disease.* VA scientists in Little Rock were part of an international team that discovered inheriting certain genetic variants from both parents significantly increases a person’s risk of developing Alzheimer’s disease.
- ◆ *Popular arthritis drugs proven dangerous for ulcer sufferers.* A new class of painkillers, COX-2 inhibitors, used to treat arthritis, may prove dangerous for some individuals. These drugs differ from conventional nonsteroidal anti-inflammatory drugs (NSAIDs) in that they block the enzyme involved in pain and inflammation (COX-2) and do not harm COX-1, which protects the stomach. However, recent VA research shows that these drugs may block the body’s natural ability to heal stomach ulcers by inhibiting the formation of tiny blood vessels that are essential to wound and ulcer healing.
- ◆ *VA research gains valuable insight into treating chronic pain associated with cancer and other diseases.* VA scientists in Minneapolis discovered that a natural chemical messenger and a neurotoxin could shut down neurons associated with chronic pain while leaving intact those needed for a normal pain response. Their research has progressed to development of a model for treating the intense pain experienced by bone cancer patients.
- ◆ *VA research achievement may lead to the development of improved artificial livers and better treatments for liver disease.* San Diego-based researchers discovered they could stimulate or inhibit growth in mouse liver cells by altering a specific gene. They believe the gene may work as a “switch” to increase cell growth in damaged livers or stop the growth of tumors.
- ◆ *VA researchers help identify sign that may help predict heart attacks.* In San Diego, VA scientists were part of a team that uncovered new information about the body’s molecular response to hypoxia, decreased oxygen levels in blood or tissue that result from heart attack or closing of cardiac blood vessels. The researchers identified a molecular marker that may help predict heart attack or ischemia.

## RESEARCH (CONTINUED)

### 2000 Achievement Highlights

#### Cooperative Studies Program

- ◆ *Testing antibiotic treatment for patients with Gulf War Veterans Illnesses (GWVI).* VA researchers are testing a possible treatment for GWVI. Although the cause of GWVI is unknown, one explanation that has received fairly wide attention holds that infection with the microorganism *Mycoplasma fermentans* may be responsible. The purpose of this study is to determine the effectiveness of a one-year course of an antibiotic called doxycycline in patients with GWVI who test positive for *Mycoplasma* species.
- ◆ *VA clinical trial shows that raising HDL prevents heart disease and stroke.* In November 2000, results of a landmark VA study were incorporated into VA and Department of Defense clinical practice guidelines for cholesterol management. The study was the first large-scale clinical trial to show that raising levels of high-density lipoprotein (HDL), the so-called “good cholesterol,” prevents heart disease and stroke. It found that the drug gemfibrozil caused a six percent increase in HDL, reducing coronary heart disease by 22 percent, nonfatal heart attack by 23 percent and stroke by 29 percent.
- ◆ *Researchers look to group-treatment model for relief of PTSD.* Despite the often devastating effects of post-traumatic stress disorder (PTSD) on veterans, there is no proven, effective method to treat this condition. This randomized clinical trial is evaluating the efficacy of trauma focus group therapy (TFGT) for treating PTSD symptoms and its effect on other psychiatric symptoms, functional impairment, physical health and utilization of medical and mental health services.
- ◆ *Assessing new approaches for treating veterans with Gulf War Veterans Illnesses (GWVI).* VA researchers are trying to determine whether cognitive behavioral therapy and aerobic exercise, two approaches that have provided relief for people with fibromyalgia and chronic fatigue syndrome, can be used to help veterans with GWVI. The study is enrolling patients into four treatment groups: cognitive behavioral therapy plus aerobic exercise, aerobic exercise alone, cognitive behavioral therapy alone, and usual and customary care. Treatment will be provided for three months and patient outcomes will be tracked for one year.
- ◆ *VA’s expertise in audiology played a critical role in the first major clinical trial of hearing aids.* A study, conducted at eight VA medical centers in collaboration with the National Institute on Deafness and Other Communication Disorders, showed that hearing aids are beneficial in both quiet and noisy environments. The results may enable primary care doctors to provide better advice and assistance to the estimated 28 million Americans—including about a third of those age 65 or older—suffering from hearing loss.
- ◆ *VA conducts largest study ever on colonoscopy for patients without symptoms.* Using colonoscopy to examine the entire colon’s lining in 3,121 apparently healthy people aged 50-75, researchers found that 10 percent had colon cancer or serious precancerous growths. Had these examinations been conducted with the commonly used sigmoidoscopy screening technique, at least a third of these lesions would have been missed. Sigmoidoscopy reveals only the lower portion of the colon’s lining.



**VISN  
Highlight**  
VISN 21  
Strategic Plan  
2001-2006

#### New Investigator Awards

For the past three years, Network leadership has provided New Investigator Awards of \$25,000 to promising young scientists who hold positions in VISN 21. The purpose of these awards is to attract and retain outstanding clinicians with strong research interests. Any physician or PhD with a faculty or staff position at or below the Assistant Professor level, who works or will work at least 50% time at a VISN 21 facility, regardless of salary source, is eligible to apply for the award.

## RESEARCH (CONTINUED)

### 2000 Achievement Highlights

#### Health Services Research and Development

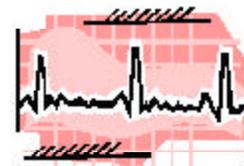
- ◆ *Computerized reminders boost doctors' compliance with standards of care.* VA findings show that computerized reminders (CRs) make a difference when physicians are reminded about adhering to standards of care. This is the first large-scale study looking at the effects of prompting physicians to follow a specified standard of care. Researchers measured adherence to standards in general terms — based on whether patients received proper care by the time of their last visit during the study; and specific terms – based on a specific patient visit. Compliance was higher among doctors using CRs. General adherence improved 10 percent and specific adherence improved 47 percent.



- ◆ *Practices identified with improved outcomes for patients with stroke.* With the emergence of effective drug therapies for the treatment of stroke, interest has increased in identifying effective practices for these patients. This study sought to describe the full array of patient outcomes associated with stroke and identify those practices associated with improved patient outcomes. Through the identification of practices associated with improved outcomes, health care providers will be able to increase the cost-effectiveness of care provided to acute stroke patients hospitalized in VA and non-VA facilities.
- ◆ *Study evaluates VA hospice care.* VHA's national health plan includes access to an organized and coordinated program of hospice care for all eligible veterans who need and want such care. This study found that hospice programs are common throughout VA and are expanding. Satisfaction with VA hospice care is high and has similar satisfaction levels to those of the non-VA population. VA has used these findings to expand or change hospice programs that will continue to improve the quality of end-of-life care.

- ◆ *Patients with diabetes benefit from reporting health information over automated phone system.* Investigators in Palo Alto utilized an automated telephone disease management (ATDM) system that allows patients with diabetes to report information about their health status and health behaviors between clinic visits, and receive individualized self-care education messages and follow-up by a nurse educator. Patients who participated reported fewer symptoms of depression, increased self-care, fewer days in bed due to illness, and greater satisfaction with their health care overall. This study shows that ATDM may be an effective strategy for improving self-care behavior and patient-centered outcomes.

- ◆ *VA patients receive high quality care for heart attacks.* The Quality Enhancement Research Initiative (QUERI) Ischemic Heart Disease group recently assessed VA treatment for patients suffering from heart attack (acute myocardial infarction, AMI). The study found that VA has comparable or superior quality of care for veterans with AMI compared to the private sector in three main areas: key validated quality measures (including the use of aspirin, beta-blockers and ACE inhibitors, and in avoiding the use of calcium channel blockers); guideline compliance; and cardiac procedure use.



- ◆ *Physicians believe in the value of home care for patients.* VA researchers in Illinois found that most physicians providing home care believed strongly in its importance and were willing to make home visits if the home care is of value to the patient, and if their time commitment is supported financially. This finding may help managed care plans further develop home care programs.

## RESEARCH (CONTINUED)



### Health Services Research and Development (continued)

- ◆ *Veterans Health Study provides outcomes information critical for VHA's quality improvement efforts.* The Veterans Health Study (VHS) followed 2,425 veteran patients for four years monitoring outcomes of care in VA and developing health status assessments. The VHS provides critical tools and information necessary to evaluate the quality of care in VHA.
- ◆ *Study links periodontitis with higher risk of heart disease and stroke.* A study using data from the VA Normative Aging Study (NAS) and the VA Dental Longitudinal Study (DLS) found that subjects with advanced periodontitis were more likely to develop chronic heart disease and were at higher risk for stroke.
- ◆ *VA care for HIV is at least as cost-effective as non-VA care.* VA is the Nation's largest provider of care to HIV-infected individuals. This study examined data from two projects that included more than 2,000 HIV-infected patients receiving care at VA facilities, non-VA facilities, or patients who used both VA and non-VA health care providers. Findings show that even after considering patients' clinical and socioeconomic characteristics, there were no differences among VA-only users, dual VA and non-VA users, and only non-VA users for most of the health care utilization measures.



### Rehabilitation Research and Development

- ◆ *Successful mobility rehabilitation in patients with medical eye conditions.* VA researchers recently completed a project to evaluate the effectiveness of three different optical enhancement systems on driving rehabilitation for patients with peripheral or central vision loss. Training in the use of special lenses (amorphic lenses for patients with peripheral visual field loss and bioptic telescopes for patients with central vision loss) resulted in greater improvement in nearly all of the visual skill areas compared to the performance of patients who received lenses but no training. From these findings, customized training programs have been developed for different types of vision loss.
- ◆ *Robot-assisted therapy more effective than conventional stroke treatment.* A group of VA scientists in Palo Alto is the first to show that robot-assisted therapy is more effective than conventional treatment for restoring upper-limb movement following stroke. The therapy produced significant improvements in strength and motor function, demonstrating that robots may help provide intensive, interactive training for patients recovering from stroke.
- ◆ *Transplantation of myelin-forming cells to the injured central nervous system (CNS).* Researchers are studying transplantation of Schwann cells that form a protein sheath around some neurons. Myelinated nerves conduct impulses more rapidly than those without myelin. Using magnetic resonance imaging, the investigators hope to establish whether cells transplanted into the primate CNS can produce myelin, the complex protein that makes up the sheath. These studies serve as a necessary prelude to human studies that may lead to use of cell transplantation as a treatment for injury to the CNS. Investigators have also successfully developed cell harvesting and preservation techniques that will further research on transplantation of myelin-forming cells.
- ◆ *Researchers identify a previously unknown dysfunction in neurons involved in multiple sclerosis (MS).* Researchers at the VA Connecticut Health Care System, West Haven Division found that a specific sodium channel, the molecular "battery" that produces electrical impulses in nerve cells, occurs in cells of brains affected by MS but not in those without neurological disease. Their work could revolutionize the treatment of MS.



## RESEARCH (CONTINUED)

### 2000 Achievement Highlights

#### Rehabilitation Research and Development (continued)

- ◆ *Better understanding of fracture risks and healing.* Individuals with spinal cord injury frequently suffer long-bone fractures in the legs, because they have reduced bone mass, are unable to sense pressure or improper limb placement, and lack the muscle strength and coordination to prevent falls. Fractures in this population can result in grave secondary complications. VA researchers have identified patterns between specific causes of fracture (e.g., fall from wheelchair) and location and type of fracture. In addition, these researchers have developed a unique Healing Index that helps identify the rate of healing that can be determined for each fracture from consecutive radiographs.
- ◆ *New methods for analyzing densitometry results can improve osteoporosis diagnosis.* Dual-energy X-ray Absorptiometry (DXA) is currently the method of choice for measuring bone density and identifying individuals with low bone mass and osteoporosis. Results can be misleading, however, because different-sized bones of the same density can produce different readings. VA researchers have developed a simple method for adjusting DXA scans of the heel bone for bone size. This new method provides an accurate determination of volumetric bone density. The researchers also developed a new DXA-based index for estimating fracture risk in normal and osteoporotic patients.
- ◆ *Improved design and function of upper limb prostheses.* A VA research initiative involving microcomputer technology will modernize the design of electric-powered upper limb prostheses. VA researchers are developing a position-sensitive controller that will improve functional performance, fitting flexibility, and ease of operation. The new controller provides sensory feedback from the prosthesis to the amputee, thus giving the amputee a better “feel” for the position of his prosthetic limb in space.
- ◆ *Effect of custom orthosis on foot kinematics and forefoot pressure distribution.* Foot ulcers related to conditions such as diabetes pose significant problems to patients and a vexing challenge to health care providers. An experimental flatfoot model is being used to determine the effects of rigid and compliant (flexible) orthoses on the movement of the foot. Computerized scans delineate the bone architecture of each foot and are used to create three-dimensional images for design of customized orthoses. Early results show that the rigid orthosis can correct eversion (outward turning) of three foot bones.
- ◆ *Preventing hearing loss due to ototoxic drugs.* VA researchers have shown definitively that ototoxic hearing loss begins primarily in the high-frequency range that is not normally tested during routine audiologic evaluation. The data have revealed a sensitive range for ototoxicity that is specific to each patient according to their degree and configuration of hearing loss. This research suggests that testing in this range only, requiring only about one-third the time of testing all frequencies, would detect about 90 percent of ototoxic hearing loss relative to full-frequency testing. This sensitive-frequency range is currently being studied to determine its actual effectiveness in patients receiving ototoxic drugs.



## RESEARCH (CONTINUED)

### Plans for 2001 - 2006

- ◆ *Clinical and economic impact of olanzapine in treating schizophrenia.* Olanzapine is a novel antipsychotic agent for the treatment of psychotic disorders, including schizophrenia, and is associated with only a few mild and often transient side effects. This study will assess the cost effectiveness of olanzapine with that of a standard antipsychotic medication, haloperidol, in the treatment of schizophrenia as measured by clinical outcome.
- ◆ *Improving amputee mobility and independence.* VA researchers in Seattle are developing new prosthetic limbs that will provide unprecedented mobility for veteran amputees. Many individuals with amputations across the shin or thigh lack endurance because of the extreme effort simply to walk with today's prosthetic limbs. To combat this problem, researchers developed an artificial muscle and tendon to replace the lost musculature of the lower limb. The resulting powered prosthetic limb, which will enter clinical testing soon, is expected to reduce patient fatigue and produce greater propulsive forces for walking.
- ◆ *Tri-National clinical trial to determine optimal antiretroviral therapy for fighting AIDS/HIV.* In an effort to find out why antiretroviral drug combination therapy has dramatically improved survival and delayed progression from HIV infection to AIDS in recent years, an international team of researchers from the Tri-National Clinical Trials Research Initiative are developing an international study to determine the most effective treatment for persons with AIDS, for whom all other treatments have not worked. Researchers on the team are from the U.S. Department of Veterans Affairs (VA), the Medical Research Council of the United Kingdom (MRC-UK) and the Medical Research Council of Canada (MRC-Canada).
- ◆ *Amyotrophic Lateral Sclerosis (ALS) among Gulf War veterans.* The Durham Epidemiologic Resource and Information Center is conducting an epidemiological investigation of the incidence of ALS among veterans of the Gulf War. The study is focusing in particular on three areas: defining the natural history of ALS; determining whether there is a higher-than-expected occurrence of ALS among Gulf War veterans; and ascertaining the possible or probable cause(s) of ALS if above normal event rates are determined.
- ◆ *Landmark prostate cancer trial will illuminate treatment options.* VA, in collaboration with the National Cancer Institute (NCI) and the Agency for Healthcare Research and Quality (AHRQ), is conducting a study that compares the two most widely used treatment methods: radical prostatectomy, in which the prostate is surgically removed, and "watchful waiting" in which only the disease symptoms are treated. This 15-year, randomized study involves 2,000 men from approximately 80 VA and NCI medical centers.
- ◆ *Enhancing the Quality of Informed Consent (EQUIC).* EQUIC is a Cooperative Studies program-wide project aimed at systematically improving the quality of informed consent by testing and measuring the results of innovative approaches to informed consent. EQUIC will field and test a method to assess the capacity of a research volunteer to understand and consent to a study; a method for "tailoring" an informed consent encounter to the vulnerabilities uncovered by that assessment, and a direct assessment of the success of an informed consent process at producing a good result, defined in terms of the successful protection of the patient's rights.
- ◆ *Conducting a major study of treatment for severe diabetes complications.* This seven-year, \$57 million VA Diabetes Trial began in July 2000. The large-scale clinical trial intends to determine whether intensified blood sugar control can prevent the major vascular complications that lead to most of the deaths, illness and treatment costs associated with type 2 diabetes.
- ◆ *Outcomes of specialized care for elderly patients evaluated.* A large, multi-outcome study will determine whether specialized inpatient and outpatient units are the best way for VA to care for elderly patients.
- ◆ *Selenium and Vitamin E Cancer Prevention Trial (SELECT).* The ideal method to reduce mortality and morbidity of prostate carcinoma is through primary prevention. Studies have suggested that dietary factors may be the most important modifiable risk factors for prostate cancer. The VA is collaborating with Southwest Oncology Group and the NCI on a trial of Vitamin E and Selenium in the primary prevention of prostate cancer.

## EMERGENCY MANAGEMENT

One of the four missions of VHA is to ensure health care for eligible veterans, military personnel, and the public during DoD contingencies and during natural, manmade, and/or technological emergencies. This section reviews 2000 accomplishments and presents future plans for VHA's emergency management program. All of these activities directly support the VA Strategic Goal to contribute to the public health and socioeconomic well-being of the Nation and the VHA Strategic Goal to build healthy communities.



The Emergency Management Strategic Healthcare Group (EMSHG) and its national network of Area Emergency Managers coordinate:

- Disaster planning, response, training, and exercises.
- Activation of the VA-DoD Contingency Hospital System.
- Activation of the National Disaster Medical System (NDMS).
- Management of NDMS Federal Coordinating Centers throughout the Nation.

VA also assists individual states and communities in times of emergency by:

- Providing direct medical care to victims of disasters.
- Providing stress counseling to disaster victims and responders.
- Augmenting staff of community hospitals, nursing homes, and other medical treatment facilities.
- Furnishing critically needed supplies, equipment, pharmaceuticals, facilities, and other resources.

To be prepared for both military and non-military emergencies, an organization must develop, test, revise, and continually update plans for many different disaster scenarios. VHA has adopted a Comprehensive Emergency Management (CEM) all-hazards approach that is based on an assessment of potential risks. Realistic plans require close coordination and training with personnel from other medical facilities, emergency medical systems state/local government agency staff, and volunteers. Through this contact and a cooperative effort, the emergency preparedness program greatly strengthens VHA's ties to the community.

VHA possesses extensive medical training and educational capabilities, including a dedicated Emergency Management Education Section, a nationwide video-teleconference system, hospital-based medical libraries, and the ability to provide professional accreditation. Emergency preparedness drills and related activities test the effectiveness of these training programs and capabilities, and keep skills honed for the real-life emergency events.

VA's emergency management program provides a national resource that is strategically placed and readily deployable throughout the country. The Comprehensive Emergency Management phases of mitigation, preparedness, response, and recovery will significantly enhance the value of VA's Emergency Management Program. VHA, as a large integrated health care system with a presence in every state, is able to provide rapid support with personnel, supplies, equipment, and other resources in times of emergency.

## EMERGENCY MANAGEMENT (CONTINUED)

### 2000 Achievement Highlights

- ◆ EMSHG coordinated emergency management response support for a variety of events, including the following:
  - ▲ Hurricane Floyd, September 15 – October 15, 1999.
  - ▲ Egypt Airlines 990 crash, November 2-23, 1999.
  - ▲ World Trade Organization Conference, November 26 – December 7, 1999.
  - ▲ Hurricane Lenny, December 1-16, 1999.
  - ▲ EMSHG Support to VA and National Y2K Efforts, December 28, 1999 – January 3, 2000.
  - ▲ State of the Union Address, January 27, 2000.
  - ▲ Republican National Convention, July 31 – August 3, 2000.
  - ▲ Democratic National Convention, August 13-17, 2000.
  - ▲ UN Millennium Meeting, September 12-17, 2000.
- ◆ In addition, EMSHG participated in a number of emergency preparedness exercises, including the following:
  - ▲ “Consequence Management 2000” – a Federal Response Plan WMD (Weapons of Mass Destruction) casualty course and exercise at Ft. Gordon, GA, May 15-20, 2000.
  - ▲ “Golden Medic” – a DOD contingency support exercise involving a UN/US response to an overseas invasion, June 11-18, 2000.
  - ▲ Y2K Exercise – a Y2K functional exercise to evaluate VA’s critical reporting and evaluation capability in the event of a variety of unforeseen Year 2000 failures, December 8-10, 2000.
  - ▲ “COOP Talk 2000” Exercise – an Interagency Contingency Communications Exercise that tested communications connectivity among participating Federal Agencies, January 24-25, 2001.

### Plans for 2001 - 2006

- ◆ Preserving the capability to respond to any kind of incident, from a local event to a major disaster, requires constant coordination and training. The EMSHG has established seven strategic goals. These goals will guide VHA’s emergency management efforts while meeting its responsibilities to veterans and the public at large.
  - ▲ Improve effectiveness of VISN emergency management programs.
  - ▲ Enhance emergency management partnerships in the Nation’s communities.
  - ▲ Ensure VA readiness to provide medical support for DoD contingencies.
  - ▲ Contribute to the emergency management knowledge base.
  - ▲ Fulfill VA NDMS responsibilities.
  - ▲ Deliver appropriate, timely, and effective disaster response services.
  - ▲ Lead VHA in preparing for emerging threats.

## Chapter 6: Resources

VHA operates the largest integrated health care delivery system in the United States, providing care to over 3.8 million unique (a single individual enrolled in the system regardless of the number of times the person was treated) patients with nearly 718 thousand inpatient stays and 38.4 million outpatient visits in 2000.

This chapter highlights:

- ❑ Workforce Development Initiative.
- ❑ Employee Education.
- ❑ Refinements to the Veterans Equitable Resource Allocation (VERA) System.
- ❑ Coordination of Federal Health Care Benefits.

### WORKFORCE DEVELOPMENT INITIATIVE

Organizations worldwide are focusing on how to preserve and foster human capital in today's rapidly changing information age. Knowledge is becoming our greatest competitive advantage and learning our greatest strategic skill. Reengineering requires a diverse, adaptive and skilled work force. Such a work force demands an innovative approach to train and empower employees to meet the challenges.



#### 2000 Achievement Highlights

- ◆ Chartered the Veterans Health Administration Workforce Strategy Team to develop a comprehensive strategy for work force recruitment, retention, and development. (October 2000)
- ◆ Used Baldrige staff focus criteria to guide development of the plan, each proposed action was cross-referenced to applicable criteria.



**VISN  
Highlight**  
VISN 8  
Strategic Plan  
2001-2006

#### Succession Planning Program

The VISN Human Resources (HR) Council, with cross-functional membership from every facility, recently initiated a succession planning program in key identified managerial/administrative areas (e.g., human resources management, financial management, health system specialist, acquisition management, medical administration management) based upon identified future and potential turnover in these key areas and VHA's Workforce 2000 projections. The succession planning program includes the placement of competitively selected trainees in VISN facilities having the expertise to develop the curriculum (with the assistance of the VISN Employee Education Workgroup), provide the training, and evaluate competency outcomes. Upon successful completion of the training curriculum and certification of competency, the trainees will be placed in managerial or managerial target position vacancies in the VISN facilities having the greatest need.

## WORKFORCE DEVELOPMENT INITIATIVE

### Plans for 2001 - 2006

- ◆ Facilitate the recruitment and retention of a talented, committed workforce to enable VHA to meet the needs of veteran beneficiaries in future years.
- ◆ Improve the physical and psychosocial work environment of employees as measured by employee surveys, focus groups, and other tools.
- ◆ Establish an incentive system for employees and managers that facilitate provision of outstanding service promoting creativity and innovation, and ensure accountability for achievement of VHA goals.
- ◆ Create a continuous staff-learning environment, based on VHA's High Performance Development Model.

## EMPLOYEE EDUCATION

Successful organizations that recognize the relationship between job-related knowledge and skills and organizational performance are increasing their investment in employee education and training. In the past two years, VHA Employee Education System (EES) has taken bold steps to revolutionize learning within VHA to create a world-class employee education model that is directly aligned with and directly supports key VHA strategic initiatives. For more information, visit their website at <http://vaww.ees.lm.va.gov>.

### 2000 Achievement Highlights

- ◆ Reorganized the Employee Education System to support the National Training Priority Areas established by the VHA Integration Advisory Council.
  - ▲ Aligned staff to 10 Employee Education Resource Centers to better partner with clients and customers.
  - ▲ Established a Headquarters Team to provide educational services to VA national program officials and staff.
  - ▲ Established VISN Teams led by Education Service Representatives and supported by an Education Specialist and Education Technician that coordinates with key VISN leaders to determine regional and facility specific education and training.
- ◆ Delivered, in collaboration with the VHA Office of Information, VA's first digital satellite network called the VA Knowledge Network. It broadcasts education and communication programming on multiple channels.
- ◆ Developed and published two editions of a quarterly newsletter entitled *EES News*.
- ◆ As described in the *One VA Update* section of Chapter 1, EES collaborated to produce the One VA Orientation Toolkits which include three videos, a checklist, print materials, and handouts for employees.
- ◆ At the May 2000 Consensus Conference: *Celebrating the Past, Assessing the Present, Shaping the Future: Discovering What is Possible*, EES collaborated with many other VHA offices to establish an environment for VHA employees to celebrate our journey through time, reevaluate, recommit, and become true partners while developing strategies and exploring visions beyond 2006.

### Plans for 2001 - 2006

- ◆ A six month VA Learning University Online (intranet) pilot that includes two virtual campuses serving 9,000 VA employees (including VHA, VBA, and NCA) in ten VA medical centers.
- ◆ Enhance communication from Headquarters to VA field employees via the VA Learning University Headquarters' Studio.

## EMPLOYEE EDUCATION (CONTINUED)

### Plans for 2001 - 2006

- ◆ Deliver video to desktop and interactive classroom training for all VA employees via the VA Knowledge Network, VA's first digital satellite network.
- ◆ Establish an integrated software package that will track educational information systemwide.
- ◆ Assist VHA in achieving its goal of becoming a Baldrige award-winning organization by developing an educational development, implementation, and evaluation plan for continuous performance improvement.

## REFINEMENTS TO THE VETERANS EQUITABLE RESOURCE ALLOCATION (VERA) SYSTEM

In 1997, VHA implemented a new system to efficiently and effectively allocate its then \$17 billion Congressionally-appropriated health care budget to its 22 networks. This new methodology, the Veterans Equitable Resource Allocation system, was created to address previously documented problems and to improve the resource allocation system in order to support VHA's goal to provide excellence in health care value. VERA is a capitation-based allocation methodology. VERA's effectiveness has been assessed by the private sector, through the PricewaterhouseCoopers study, and by two government sponsored General Accounting Office (GAO) reviews. All three of these studies viewed the success of VERA in positive terms and as meeting the intent of Congress.

VHA has an ongoing process to continually review and refine the VERA methodology. There are several VERA workgroups, comprised of VHA field-based and VHA headquarters' staff that provide ongoing evaluation and input on policy issues to improve VERA. Many of the recommendations from the three studies have been reviewed by VERA workgroups and implemented in the 1999, 2000 and 2001 VERA methodologies. For more information, visit the website at <http://vaww.arc.med.va.gov>.



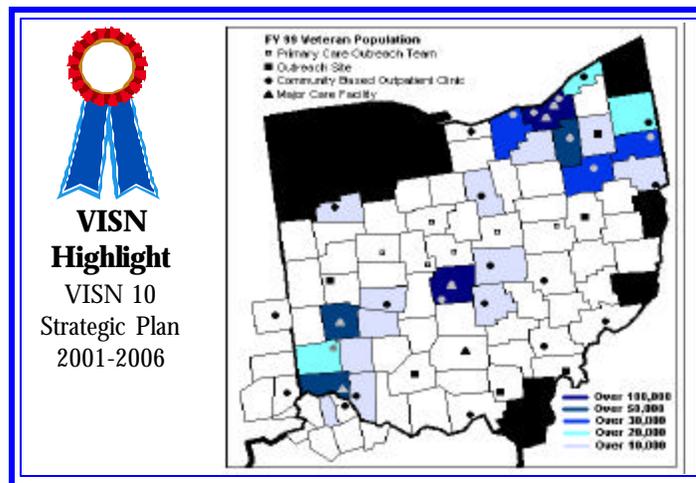
### 2000 Achievement Highlights

- ◆ Approved the following VERA policy changes or refinements for the 2001 network budget allocations:
  - ▲ Hepatitis C – developed VERA Basic and Complex patient classes and criteria based on appropriate diagnosis and active drug therapy for hepatitis C virus patients.
  - ▲ Complex Care projection methodology – adjusted the complex care projection methodology in VERA to delete the veteran population factor from the calculation. The projection is now based on historical utilization.
  - ▲ Research Support – passed through VERA research support funds directly to each VA medical center again in 2001.
  - ▲ Geographic Price Adjustment – changed the workload factor for computing the labor index that weights Basic and Complex Care workload consistent with recent costs.
  - ▲ Supplemental Funding Process – VHA Headquarters will no longer have field teams review supplemental requests. Requesting Network Directors will present a justification of need to the Deputy Under Secretary for Health and the VHA Chief Financial Officer via videoconference in September for the next fiscal year. The Under Secretary for Health will make the final supplemental funding decisions and financial review boards will assist those networks who are provided supplemental funding.
  - ▲ Non-Recurring Maintenance (NRM) – completed the three-year phase-in of NRM based fully on patient care workload and the cost of construction.

## REFINEMENTS TO THE VETERANS EQUITABLE RESOURCE ALLOCATION (VERA) SYSTEM (CONTINUED)

### Plans for 2001 - 2006

- ◆ Contract with a Federally Funded Research and Development Center to study VERA no later than 60 days from the enactment of Public Law 106-377, VA's 2001 Medical Care Appropriation, to determine whether VERA's methodology leads to a distribution of funds that covers the special needs of some veterans and to investigate the progress of this funding allocation method. Incorporate results of VERA study in future refinements and improvements to the VERA methodology.
- ◆ Examine several VERA refinements for potential implementation in 2002 or beyond in the areas of: patient classifications, priority 7 veterans and market share, the effect of patients above age 75 that an AMA Systems, Inc. report, "Evaluation of Patient Health Status by VISN," (completed in July 2000) demonstrates is associated with a sharp increase in costs, and a review of the existing geographic price adjustment formula.



## COORDINATION OF FEDERAL HEALTH CARE BENEFITS

Many veterans are eligible for non-VA medical care, often through Medicare or the Department of Defense. The use of multiple systems can make it extremely difficult to track and coordinate the total health care provided to these veterans. This can lead to duplication of care and/or fragmentation of services, possibly leading to negative consequences in terms of cost, patient safety, and quality of care. As an example, many Medicare eligible veterans are enrolled in Medicare+Choice plans and also use the veterans health care system. This means that Medicare is paying HMOs the full capitation rate for many veterans who also rely on VA for their care. Conservative estimates show the service provided to these veterans by VA is more than \$150 million.

The Millennium Health Care and Benefits Act requires VA and DoD to enter into an agreement whereby DoD will pay VA for the health care of Priority 7 TRICARE eligibles. In addition, VA is entering into a data merge agreement with HCFA to obtain data on health care services provided VA enrollees outside VA through their Medicare benefits. This will lead to a better understanding of the total health care utilization of VA enrollees. Congress is also considering a number of legislative proposals to ensure coordination and clarification of benefits to address both duplication of care and gaps in services to veterans.

## Chapter 7: Information Management

Veterans Health Administration's information systems (IS) and communication goals and objectives are at the center of health care delivery. Many of the central tenets of VHA and One VA strategy are essential elements of modern health care delivery with its emphasis on integration of care and access to quality care and services. VHA is relying more heavily on IS to improve patient access to quality, effective, and cost-effective health care. The Veterans Health Information Systems and Technology Architecture (VISTA) is the major information system today that automates all major clinical management and administrative functions throughout VHA. VistA includes both "in-house" developed and commercially purchased software.



VHA is moving to an "ideal" health information system strategy supporting the "ideal" veterans health system. The major systems or program/business needs are in the following areas: registration/enrollment/eligibility, health data, health care providers, management/financial, and information/education (electronic communications and transactions). Cross cutting issues are security/privacy, data quality, information technology architecture, infrastructure, and leadership/management. For more information on OI, go to <http://vaww.va.gov/vhacio>.

This chapter highlights:

- Improving VHA's Information Systems .
- Security.
- Data Standardization and Quality.
- Communications Strategy.

### IMPROVING VHA'S INFORMATION SYSTEMS

The Office of Information (OI) provides information systems services that support delivery of the best health care to veterans. OI's policy is to pursue the most cost-effective methods of obtaining information systems to satisfy VISN needs in concert with stated agency goals and business objectives. VHA's future course of action will be to meet emerging health system needs with a mix of in-house and commercial solutions within five major systems and cross cutting issues.

- Health Data System.**  
The health data system (health data repository [HDR]) will create a true longitudinal health care record including data from both VA and non-VA sources. Other benefits are improved information to support research and population analysis, facilitated patient access to data, sharing of information across VHA, improved data quality, and a reduced burden on local VISTA systems.
- Registration, Enrollment, Eligibility System.**  
Registration, enrollment, and eligibility have strong VHA and One VA components. For One VA, there is a need for a common system and demographic database supporting registration and eligibility for the three administrations that makes information more accessible and consistent. In addition, VHA will develop and manage the companion VHA registration, enrollment, and eligibility to meet unique VHA requirements.

## IMPROVING VHA'S INFORMATION SYSTEMS (CONTINUED)

### ❑ **Provider Systems .**

Provider systems are those information systems supporting health care providers' care for veterans and feed information to the main systems such as VISTA today and the Health Data Repository in the future. Systems include Computerized Patient Record System (CPRS), Vista Imaging, Blood Bank, Pharmacy, Laboratory, Government Computer-based Patient Record (GCPR), and scheduling.

### ❑ **Management and Financial Systems .**

The management and financial systems include Integrated Funds Distribution Control Point Activity, Accounting and Procurement (IFCAP); Billing; Accounts Receivable (AR); and Fee Basis. Each is more than 10 years old. They are a) difficult to maintain, b) not Health Insurance Portability and Accountability Act (HIPAA) and Millennium Bill compliant, c) lack system integration, d) lack edits and data check, and e) lack a modern graphics user interface. Since these systems are not considered core competencies of VHA, they will be replaced by commercial applications, including CoreFLS.

### ❑ **Information and Education Systems.**

Information and Education, with an emphasis on "e", will improve service to veterans and other key stakeholders by ensuring all desired information is accurate, up-to-date, and readily available any place, anytime via electronic means. The VA internet will increasingly be the primary electronic gateway to trusted VA information and services to veterans and their families.

The following offices within OI are responsible for designing and implementing the five information systems:

#### ❑ **Enterprise Strategy (ES).**

ES assesses emerging information technologies and help set direction for VHA information systems and services supporting delivery of the best health care to veterans, now and in the future.

#### ❑ **System Design & Development (SDD).**

SDD develops national software and systems solutions in support of VHA's health care delivery mission.

#### ❑ **Customer Support (CS).**

CS provides nationwide support and problem resolution for VHA information systems procurement, security, applications, and platforms.

#### ❑ **System Implementation (SI).**

SI provides implementation support and training for new information management systems throughout VHA.

#### ❑ **Enterprise System Management (ESM).**

ESM manages the five major program information systems through all stages of the project life cycle, ensuring project coordination, timeliness, and responsiveness.

### 2000 Achievement Highlights

- ◆ VISTA Documentation Library on the Systems & Design webpage.
- ◆ Moved the OI organization to a single service center to improve efficiency and accountability.
- ◆ Completed the Veteran Focused Internet Home Page improving the "look and feel" of the VA Internet.
- ◆ Released the VHA Enterprise Architecture 2001 to establish an enterprise wide approach.
- ◆ Online 10-10-EZ enables veterans to apply for VA health care benefits using web-based technology.
- ◆ Replaced the 10 year old analog satellite television network with digital equipment for more dependable service and higher quality reception.
- ◆ The VA internet gateways expanded to accommodate the traffic increase from 200,000 messages per month to over 4 million messages per month over the past year.

## IMPROVING VHA'S INFORMATION SYSTEMS (CONTINUED)

### 2000 Achievement Highlights

- ◆ Local area network monitoring systems were procured and installed in all VISNs enabling support staff to proactively work with the sites and VISNs to diagnose network issues quickly.
- ◆ Thirteen VHA Privacy Act Systems of Records (SOR) Notices were amended and fifteen new SORs were compiled, seven of which were published in the Federal Register.
- ◆ Monthly compliance satellite TV broadcasts were presented to national administrative and clinical staffs.
- ◆ Implemented Bar Code Medication Administration system to increase efficiency and safety of medication administration. Bar Code Medication Administration Team was awarded the Hammer and Scissors Awards.
- ◆ Released Automated Safety Incident Surveillance Tracking System (ASISTS) national database that will improve tracking and management of employee accidents.
- ◆ The Government Computer-based Patient Record framework proof of concept was successfully demonstrated. The project was recognized as a "Best Practice" receiving the Pioneer Award in July at E-Gov 2000.
- ◆ CPRS Update/Remote Patient Data View was made available to all sites enabling clinicians to access remote data from another CPRS system.
- ◆ The credentialing data bank VetPro was implemented nationally.
- ◆ The VA Wide Area Network was upgraded to a high-speed, scalable, network using an Asynchronous Transfer Mode (ATM) backbone.
- ◆ The Resident Assessment Instrument/Minimum Data Set (RAI/MDS), a long term care assessment tool, was made available for use in VA Nursing Homes, intermediate, and sub acute care areas.

### Plans for 2001 - 2006

- ◆ Develop and implement "ideal" health information system strategy supporting the "ideal" veterans health system. The major systems or program/business needs are in the following areas: registration/enrollment/eligibility, health data, health care providers, management/financial, and information/education (electronic communications and transactions).
- ◆ Maximize support of health.
- ◆ Monitor and ensure high system performance.
- ◆ Constructive collaboration between users and CIO.
- ◆ Maximize use/sharing of all valuable information.
- ◆ Maximize use of best appropriate technology.
- ◆ Effectively manage across program, time, budget.
- ◆ Balance resource needs of health and information.



**VISN  
Highlight**  
VISN 2  
Strategic Plan  
2001-2006

### Homeless Integrated Database

As VISN 2 moved from a silo model of homeless service delivery to an integrated continuum of care, there was a need to develop an integrated data collection process in order to provide a more timely, cost effective, and coordinated service delivery system to homeless and at risk veterans. A software program was implemented in the Fall of 2000. The initial database was established primarily to monitor the key performance measures related to the care of the homeless patient, i.e., employment and housing. The existing database now provides the VISN homeless staff and care line managers, at both the VISN and site levels, with the ability to create "real time" reports that are easily understood and utilized by the provider to enhance the veterans' health care.

## SECURITY

Presidential Decision Directive 63 (PDD-63) is the culmination of an intense interagency effort to assure the security of our increasingly vulnerable and interconnected information infrastructures and essential Government services. The Directive sets goals to achieve a reliable, interconnected, and secure information system infrastructure by the year 2003. The Congressional Subcommittee on Government Management issued the first Government-wide report card on Computer Security. Several weaknesses were cited in VA's report with much room for improvement. In October 2000, VA issued an Information Security Management Plan for improving information security within the department and attaining an "A" by June 2001.



### 2000 Achievement Highlights

- ◆ Developed guidance on reporting requirements and instructions for completing action items.
- ◆ The fourth annual information security conference, InfoSec2000, offered 60 sessions for 350 attendees.

### Plans for 2001 - 2006

- ◆ Implement action items to the Subcommittee's report to achieve a grade "A" by June 2001. Facilities are required to certify that required actions are completed and that security is in full compliance with Department and VHA policies and standards.
  - ▲ Implement Windows NT enterprise security policy (strong password).
  - ▲ Remove unsecured dial-in connections.
  - ▲ Require incident reporting to VA computer incident reporting capability (CIRC) as a standard practice.
  - ▲ Correct personnel controls on system administrator staff.
  - ▲ Implement configuration standards for external electronic connections.
  - ▲ Staff effective information security officer (ISO) positions.
  - ▲ Deploy VA-standard role-based security training.
  - ▲ Deploy enterprise-wide anti-virus regime.

## DATA STANDARDIZATION & QUALITY

Data reliability, accuracy, and consistency have been a targeted focus of Veterans Health Administration (VHA) for the past several years. Office of Information Assurance is developing strategies and standard approaches to help field staff understand the data content and meaning of specific data elements in VHA databases. Additionally, the office is involved in key projects targeted to improve data quality and system reliance—the Meta Data Registry and the Master Patient Index. The office is also involved in providing guidance, training, and education sponsoring satellite television broadcasts on data quality issues.



### 2000 Achievement Highlights

- ◆ Created, approved, and filled the position of Data Quality Coordinator in the Office of Information.
- ◆ Expanded VHA participation on National Standards committees including the Systematized Nomenclature of Medicine and the American National Standard Institute.
- ◆ VHA's OI newsletters.
  - ▲ "Close Encounters," which provides expert guidance to field facilities on encounter forms, insurance billing, coding, and Medicare compliance.
  - ▲ "Data Quality Highlights," which provides data quality facts and tips.

### Plans for 2001 - 2006

- ◆ Support the integrity and data quality of coding.
  - ▲ Develop strategies and standard approaches to help field staff understand the data content and meaning of specific data elements in VHA databases.
  - ▲ Complete revision of VISTA software to accommodate the use of national code set modifiers, giving providers the ability to document care more completely and accurately.
- ◆ Provide training and education opportunities to staff that support data quality initiatives and compliance.
- ◆ Increased VA participation on national standards committees.
- ◆ Modify all VA systems to comply with the Health Insurance Portability and Accountability Act (HIPAA).
- ◆ Expand the Master Patient Index unique identifier to all systems that include patient data.
- ◆ Implement a national demographic database to be used as the authoritative source by all VA.

## COMMUNICATIONS STRATEGY

The Department of Veterans Affairs is the Nation's largest health care delivery system with more than 1,315 total operating sites and 180,000 employees serving an enrolled patient population of 3.9 million veterans annually. While Veterans Health Administration (VHA) health care professional groups, managers, and specific program areas traditionally and fairly effectively have communicated within their own circles, there has been a deficiency in the conveyance of information from Headquarters to the field and associated feedback. The Office of Communications is to facilitate open communication that fosters awareness and understanding among employees, patients, and the general public about VHA's commitment to veteran service, quality of care (including patient safety), medical research, and the education of the Nation's health care professionals.



### 2000 Achievement Highlights

- ◆ Filled position of Chief Communications Officer. (November 2000)
- ◆ Reorganized the Office of Communications.

### Plans for 2001 - 2006

- ◆ Form a Communications Advisory Council of public affairs practitioners within the system, health care professionals, managers, and others to develop and begin implementing a comprehensive, precise communications strategy for the health care system, with measures for regular assessment of its impact, and which supports the Administration's, the Department's and VHA's strategic goals.
- ◆ Survey private sector and other government communications programs.
- ◆ Chief Communications Officer will launch a newsletter for Headquarters and field personnel that will contain news, interesting facts about VHA achievements and services. The newsletter will also be shared with patients, national and local veterans' service organizations, and Congressional staffs.
- ◆ Chief Communications Officer will institute production of a monthly 30-minute program on VA health care issues to be broadcast on the system's satellite network to all facilities.

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## Glossary of Acronyms

ACSI:	American Customer Satisfaction Index
ADA:	American Diabetes Association
AHRQ:	Agency for Healthcare Research and Quality
AIDS:	Acquired Immune Deficiency Syndrome
ALS:	Amyotrophic Lateral Sclerosis
AMI:	Acute Myocardial Infarction
AR:	Accounts Receivable
ASI:	Addiction Severity Index
ASISTS:	Automated Safety Incident and Surveillance Tracking System
ASQ:	American Society for Quality
ATDM:	Automated Telephone Disease Management
ATM:	Asynchronous Transfer Mode
BROS:	Blind Rehabilitation Outpatient Specialist
CARES:	Capital Asset Realignment for Enhanced Services
CARF:	Commission on Accreditation of Rehabilitation Facilities
CBOC:	Community Based Outpatient Clinic
CEM:	Comprehensive Emergency Management
CHALENG:	Community Homelessness Assessment, Local Education & Networking Groups
CIRC:	Computer Incident Reporting Capability
CMOP:	Consolidated Mail Out Pharmacy
CNS:	Central Nervous System
CSD:	Coordinator for Special Disabilities
CPRS:	Computerized Patient Record System
CR:	Computerized Reminders
CWT:	Compensated Work Therapy
DCHV:	Domiciliary Care for Homeless Veterans
DoD:	Department of Defense
DoL:	Department of Labor
EDI:	Electronic Data Interface
EES:	Employee Education System
EMSHG:	Emergency Management Strategic Healthcare Group
EQUIC:	Enhancing the Quality of Informed Consent
FDA:	Food and Drug Administration
FSOD:	Functional Status and Outcomes Database

GAF:	Global Assessment of Functioning
GAO:	Government Accounting Office
G-CPR:	Government Computer-based Patient Record
GPD:	Homeless Providers Grant and Per Diem Program
GPRA:	Government Performance and Results Act
HCV:	Hepatitis C Virus
HCHV:	Health Care for Homeless Veterans
HDR:	Health Data Repository
HHS:	Department of Health and Human Services
HIPAA:	Health Insurance Portability and Accountability Act
HUD:	Department of Housing and Urban Development
IFCAP:	Integrated Funds Distribution Control Point Activity, Accounting and Procurement
IOM:	Institute of Medicine
IRB:	Institutional Review Board
IS:	Information Systems
ISO:	Information Security Officer
IT:	Information Technology
JCAHO:	Joint Commission on Accreditation of Healthcare Organizations
LTC:	Long Term Care
MD:	Medical Doctor
MDS:	Minimum Data Set
MOA:	Memorandum of Agreement
MS:	Multiple Sclerosis
NCA:	National Cemetery Administration
NCI:	National Cancer Institute
NCQA:	National Committee of Quality Assurance
NCPS:	National Center for Patient Safety
NCSC:	National CARES Steering Committee
NDMS:	National Disaster Medical System
NHCU:	Nursing Home Care Unit
NOFA:	Notice of Funding Availability
NRM:	Non-Recurring Maintenance
NSAIDs:	Nonsteroidal Anti-inflammatory Drugs
OHI:	Office of Healthcare Inspections
OMB:	Office of Management and Budget

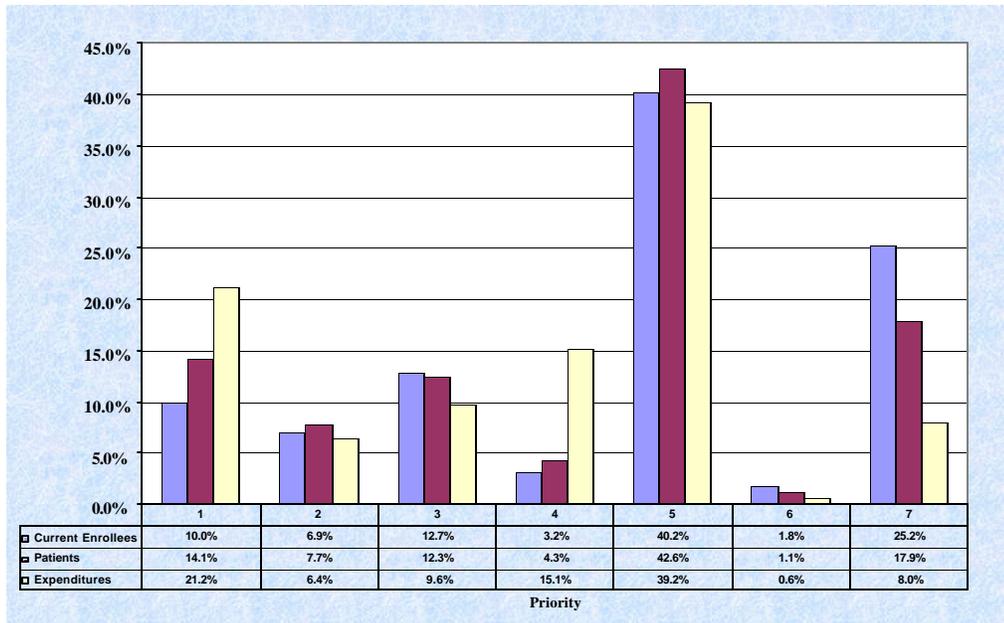
PACT:	Preservation/Amputation Care and Treatment
PDD:	Presidential Decision Directive
PL:	Public Law
PQA:	President's Quality Award
PSAS:	Prosthetics and Sensory Aids Service
PSCI:	Patient Safety Centers of Inquiry
PSRS:	Patient Safety Reporting System
PTSD:	Post Traumatic Stress Disorder
QUERI:	Quality Enhancement Research Initiative
RAI:	Resident Assessment Instrument
RCA:	Root Cause Analyses
RCS:	Readjustment Counseling Service
RIT:	Rochester Institute of Technology
RFP:	Request for Proposal
SCI:	Spinal Cord Injury
SCI&D:	Spinal Cord Injury & Disorders
SEP:	Special Emphasis Program
SMI:	Seriously Mentally Ill
SOR:	System of Records
SRPVH:	Special Recognition Program in Veterans Health
TBI:	Traumatic Brain Injury
TFGT:	Trauma Focus Group Therapy
USH:	Under Secretary for Health
VA:	Department of Veterans Affairs
VAHQ:	VA Headquarters
VAMC:	VA Medical Center
VBA:	Veterans Benefits Administration
VERA:	Veterans Equitable Resource Allocation
VHA:	Veterans Health Administration
VHS:	Veterans Health Study
VHSS:	Veterans Health Service Standard
VISN:	Veterans Integrated Service Network
VIST:	Visually Impaired Service Team
VISTA:	Veterans Health Information Systems & Technology Architecture
VSO:	Veteran Service Organization



# Updates on Selected Charts/Graphs

## CHAPTER 1: STRATEGIC MANAGEMENT

**Chart 1.1 Update** Percentage of Enrollees, Patients, and Expenditures by Priority for Nation as of February 26, 2001.



**Chart 1.2 Update** Current Enrollees and Actuary Projections by Priority for Nation.

